MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2637

CERTIFICATE OF DEATH

Reg. Dist. No. 0258

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 24 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 419 Crain Highway SE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 419 Crain Highway SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: H. — Last: Adams, Sr

4. DATE OF DEATH: Month: 3 — Day: 4 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 22, 1874

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Printer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Adams

14. MOTHER'S MAIDEN NAME: Julia Longworth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 215-10-8737

17. INFORMANT: Mrs Mary Ellen Adams, same as 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) Hypertensive Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

4437

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1957 to March, 1959, that I last saw the deceased alive on March 3, 1959, and that death occurred at 6 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R MacDonald MD M.D.

ADDRESS (Street, city or town, state): 204 Crain Highway SW, Glen Burnie

DATE SIGNED: 3-5-59

PHYSICIAN'S NAME (Type): C. R. MacDonald, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/7/59

22c. NAME OF CEMETERY OR CREMATORY: Oak Lawn

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping and Kirkley, Glen Burnie, Md.

ADDRESS:

24a. REC'D BY REGISTRAR: DATE MAR 6 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2594

CERTIFICATE OF DEATH

02585 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION A.A. General Hospt.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md.
b. COUNTY A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS 1108 West St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First George Middle W. Last Aduiotis
4. DATE OF DEATH Month 3 Day 24 Year 1959
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH April 26 1916
9. AGE (In years last birthday) 42 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Amusement Co
10b. KIND OF BUSINESS OR INDUSTRY Coin Machine
11. BIRTHPLACE (State or foreign country) GREECE
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Aduiotis
14. MOTHER'S MAIDEN NAME Maria Kasapis
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO.
17. INFORMANT Beatrice Aduiotis Address #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
420.1
DUE TO
(b) Coronary artery disease — 6 mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to March, 1959, that I last saw the deceased alive on March 24, 1959, and that death occurred at 7:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE John A. Hedeman M.D. ADDRESS (Street, city or town, state) 121 Cathedral DATE SIGNED 3/25/59
PHYSICIAN'S NAME (Type) Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF 3-27-59
22c. NAME OF CEMETERY OR CREMATORY St. James
22d. LOCATION (City, town, or county) (State) Annapolis Md.

23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons ADDRESS Annapolis, Md.
24a. REC'D BY REGISTRAR DATE MAR 30 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2595

Reg. Dist. No. 02586

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 4 Yrs. Approx

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: Seven Oaks, Wardour
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Seven Oaks, Wardour, Anna. Md.

3. NAME OF DECEASED (Type or print): First: Laurie — Middle: Elward — Last: ALLGOOD

4. DATE OF DEATH: Month: MAR — Day: 25 — Year: 19 59

5. SEX: F

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 31 Jan 1892

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife-Realtor

10b. KIND OF BUSINESS OR INDUSTRY: Housewife-Realtor

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Elward SMITH

14. MOTHER'S MAIDEN NAME: Frances CAIRNS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 076-12-6433

17. INFORMANT: CAPTAIN Elward Baldridge — Address: 214 Wolfe Street Alexandria, Virginia

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO
(b): Hypertensive cardiovascular disease — Yrs.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

443×

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1957, 19___, to March, 19 59, that I last saw the deceased alive on March 10, 19 59, and that death occurred at ___M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John L. Hedeman M.D.

ADDRESS (Street, city or town, state): 121 Cathedral Street, Annapolis, Md.

DATE SIGNED: 3/27/59

PHYSICIAN'S NAME (Type): John L. HEDEMAN

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal-burial

22b. DATE THEREOF: March 27, 59

22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery

22d. LOCATION (City, town, or county) (State): Woodlawn, New York

23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME

ADDRESS: Annapolis, Maryland

24a. REC'D BY REGISTRAR DATE: MAR 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02587

2596 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: AA General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Gambrills
d. STREET ADDRESS: Naval Academy Dairy Farm
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Jauniata — Middle: Mamie — Last: Anderson
4. DATE OF DEATH: Month: March — Day: 1, — Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Jan. 8, 1939
9. AGE (In years last birthday): 20 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Tennessee
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wallace Roberts
14. MOTHER'S MAIDEN NAME: Ellie Vaughn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Charles Anderson, same as 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 Hrs
754.7
DUE TO (b): Congenital Aneurism
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pregnancy 4½ Mo 6149x
19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT, WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 19, 1959 to Mar 1, 1959 that I last saw the deceased alive on Mar 1, 1959, and that death occurred at 6:05 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward G. Skerritt M.D. — ADDRESS (Street, city or town, state): Gambrills Md — DATE SIGNED: 3-3-59

PHYSICIAN'S NAME (Type): Edward G. Skerritt, M.D. Gambrills, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/4/59
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven Memorial
22d. LOCATION (City, town, or county) (State): Glen Burnie, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: Hopping and Kirkley, Glen Burnie, Md.
24a. REC'D BY REGISTRAR — DATE: MAR 4 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kuhn

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2638 CERTIFICATE OF DEATH

Reg. Dist. No. 02588

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena RFD
c. LENGTH OF STAY IN 1b: 4 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Long Point

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Long Point (Pasadena RFD)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: S. — Last: Angel

4. DATE OF DEATH: Month: March — Day: 4 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 3, 1907

9. AGE (In years last birthday): 51 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffer

10b. KIND OF BUSINESS OR INDUSTRY: Self Emp.

11. BIRTHPLACE (State or foreign country): W. Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James T. Angel

14. MOTHER'S MAIDEN NAME: Mae (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Rachael Angel — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 2 months

163X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Carcinoma of the Lungs — 2 months

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 3 1959 to March 4, 1959 that I last saw the deceased alive on March 4, 1959 and that death occurred at 2:10 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. — ADDRESS (Street, city or town, state): RFD 8 Box 442 Pasadena, Md. — DATE SIGNED: Mar. 4, 1959

PHYSICIAN'S NAME (Type): R. M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 7, 1959

22c. NAME OF CEMETERY OR CREMATORY: London Park

22d. LOCATION (City, town, or county) (State): Balto., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. P. Serafilter — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: MAR 5 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02589

Item 7, File G241, 4/10/59 icy

Reg. Dist. No

1. PLACE OF DEATH
a. COUNTY 2639 Anne Arundel MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 4 Box 28A. Annapolis

2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission)
a. STATE Maryland b COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS Rt. 4 Box 28A
e. IS RESIDENCE ON A FARM YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Estella Middle B. Last Baldwin

4. DATE OF DEATH Month 3 Day 30 Year 1959

5. SEX Female

6. COLOR OR RACE Col.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 12-26-1893

9. AGE (In years last birthday) 65 yrs

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HR: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10b. KIND OF BUSINESS OR INDUSTRY Hutzler's family

11. BIRTHPLACE (State or foreign country) A. A. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME Job Stansbury

14. MOTHER'S MAIDEN NAME Delia Stansbury

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO 212-32-0547

17. INFORMANT Evelyn Addison Address Rt. 4 Box 28A. Anna. Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH Minutes

DUE TO (b) 4344

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o m p m Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from. Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE [signature] M D

EXAMINER'S NAME (Type) E. L. Inhorn

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

DATE SIGNED 3/30/59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 4-3-59

22c. NAME OF CEMETERY OR CREMATORY Broad Neck

22d. LOCATION (City, town, or county) (State) St. Margarets, Md.

23. FUNERAL DIRECTOR'S SIGNATURE William Leese, II ADDRESS Anna. Md.

24a. REC'D BY REGISTRAR DATE MAR 31 '59

24b. REGISTRAR'S SIGNATURE [signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

ASME BM 2.57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02590

2640

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Jessup, Md.
c. LENGTH OF STAY IN 1b: 18 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Md. House of Correction Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: ~~Worcester~~ Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS:
e. RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First M James; Middle; Last Bell

4. DATE OF DEATH: Month March; Day 7; Year 19 59

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-6-10

9. AGE (In years last birthday): 48 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Bell

14. MOTHER'S MAIDEN NAME: Belle Carry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gangrene of Small Bowel
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Adhesive Band
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): patial

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): partial

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: 3/8/59

EXAMINER'S NAME (Type): Charles S. Petty

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-13-59
22c. NAME OF CEMETERY OR CREMATORY: Silent City
22d. LOCATION (City, town, or county) (State): Cambridge, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: LEON HENRY, 222 Cedar St., Cambridge, Md.

24a. REC'D BY REGISTRAR DATE: APR 1 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Preece

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2 57

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom portion may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2641

CERTIFICATE OF DEATH

02591

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY: Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lakeshore

LENGTH OF STAY (in this place): 4 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 5 Luke Drive

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lakeshore

STREET ADDRESS (If rural give location): 5 Luke Drive

3. NAME OF DECEASED (Type or Print): (First) Keith (Middle) Eugene (Last) Bennett

4. DATE OF DEATH: (Month) March (Day) 2, (Year) 19 59

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married	July 25 1919	39 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Projectionist	Motion Pictures	Maryland	U.S.A.

13. FATHER'S NAME: Max Bennett

14. MOTHER'S MAIDEN NAME: Mary Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
Yes	World War II	?	Jean Bennett 5 Luke Drive

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A): Circulatory Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 Hours

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B): Weight Loss, Widespead Metastases — 1 year

DUE TO (C): Carcinoma of Testis

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED White at work ☐ Not white at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from on 3-2, 19 59, to ....., 19....., that I last saw the deceased alive on 3-2, 19 59, and that death occurred at 6:10 P.M. from the causes and on the date stated above.

SIGNATURE: Otto Vogel MD — ADDRESS (Street, city, town, state): 403 Ritchie Hwy, Glen Burnie — DATE SIGNED: 3-3-59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3/5/59	Baltimore National	Baltimore, Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
MAR 6 '59	Arthur L. Kraus	Geo. L. Schwab Funeral Home Barbara M. Schwab 2101 Fredonia Ave

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02592

Reg. Dist. No. 2642

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town):
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Severna Park
d. STREET ADDRESS:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Severna Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First VELETA Middle T. Last BEST
4. DATE OF DEATH: Month March Day 18 Year 1959
5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-16-1958
9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months 4 Days
IF UNDER 24 HRS: Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Balto, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Elbert E. Best
14. MOTHER'S MAIDEN NAME: Lillie M. Jackson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Lillie M. Jackson Address: Severna Park

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Septicemia due to otitis media, bilateral
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Russell S Fisher M.D.
CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
DATE SIGNED: March 18, 1959
EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 3-20-59
22c. NAME OF CEMETERY OR CREMATORY: Carpenter Hill
22d LOCATION (City, town, or county) (State): Round Bay Md.
23. FUNERAL DIRECTOR'S SIGNATURE: Whitecroft
ADDRESS: 103 Main St. Annapolis Md.
24a. REC'D BY REGISTRAR DATE: MAR 23 '59
24b REGISTRAR'S SIGNATURE: Louise S. Hearn

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and if any event within 72 hours after death.

VS AISME
BM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2597 **CERTIFICATE OF DEATH** 02593

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY A. A. MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Anne Arundel

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis Md. c. LENGTH OF STAY IN 1b 24 Yrs

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel Gen Hosp

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Charles Middle — Last Bissett

4 DATE OF DEATH Month 3 Day 2 Year 1959

5. SEX M.

6. COLOR OR RACE W.

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH July 31, 1913

9 AGE (In years last birthday) 45 yrs

IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer

10b KIND OF BUSINESS OR INDUSTRY Navy

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY U.S.

13 FATHER'S NAME Unknown

14 MOTHER'S MAIDEN NAME Unknown

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 054-01-1263

17. INFORMANT Wife Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b) Coronary failure

DUE TO (c) Generalized Arteriosclerosis

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1957, 19___, to 1959, 19___, that I last saw the deceased alive on 3-1-59, 19___, and that death occurred at 3:30 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Robert Ritchie M.D. ADDRESS (Street, city or town, state) Severna Park Md DATE SIGNED 3-2-59

PHYSICIAN'S NAME (Type) Robert Ritchie MCT

22a BURIAL, CREMATION, REMOVAL (Specify) Burial

22b DATE THEREOF March 9 59

22c NAME OF CEMETERY OR CREMATORY Asbury Meth Church Cemetery

22d LOCATION (City, town, or county) (State) Arnold Anne Arundel Co Md

23. FUNERAL DIRECTOR'S SIGNATURE Bernard G Fink ADDRESS Glen Burnie Md

24a REC'D BY REGISTRAR DATE MAR 11 59

24b. REGISTRAR'S SIGNATURE Clifton T. Perkins

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

62595

2643

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Md
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
d. STREET ADDRESS: Tick Neck Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Edward Middle: S. Last: Bradley.

4. DATE OF DEATH: Month: March Day: 18, Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8 DATE OF BIRTH: April 10, 1874

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b KIND OF BUSINESS OR INDUSTRY: Lumber Mill

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown

14 MOTHER'S MAIDEN NAME: Unknown.

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 213-34-4288

17 INFORMANT: Address: Clifton Bradley. Tick Neck Rd.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO: Generalized arteriosclerosis — several years

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic CVD & cardiac decompensation, Acute bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1, 1956 to March 18, 1959, that I last saw the deceased alive on March 17, 1959, and that death occurred at 1:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. — ADDRESS (Street, city or town, state): RFD 8 Box 442 Pasadena, Md. — DATE SIGNED: March 18 1959

PHYSICIAN'S NAME (Type): R M McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/21/59

22c NAME OF CEMETERY OR CREMATORY: Oak Lawn

22d. LOCATION (City, town, or county) (State): Eastern Ave, Md.

23 FUNERAL DIRECTOR'S SIGNATURE: Austin E. Donovan — ADDRESS: 3818 Roland Ave

24a. REC'D BY REGISTRAR DATE: MAR 23 '59

24b REGISTRAR'S SIGNATURE: Arthur S. Krauss

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items6,7,11,12,13,14 FilmG239 3-9-59 et

02598

2598

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Annapolis, Md.
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle — Last BROOKS
4. DATE OF DEATH: Month March — Day 1 — Year 1959.
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ ? DIVORCED ☐
8. DATE OF BIRTH: 1-2-05
9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caretaker
10b. KIND OF BUSINESS OR INDUSTRY: Beach
11. BIRTHPLACE (State or foreign country): ?
12. CITIZEN OF WHAT COUNTRY? ?
13. FATHER'S NAME: ?
14. MOTHER'S MAIDEN NAME: ?
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 49 v-X
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 1, 1959, to March 1, 1959, that I last saw the deceased alive on March 1, 1959, and that death occurred at 2:25A M, from the causes ond on the date stated above.

ACTUAL SIGNATURE: Aris T. Allen M.D
ADDRESS (Street, city or town, state): 62 Cathedral St., Annapolis, Md.
DATE SIGNED: 3/3/59
PHYSICIAN'S NAME (Type): Aris T. Allen

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 3-3-59
22c. NAME OF CEMETERY OR CREMATORY: Annapolis Rural Cem. Md.
22d. LOCATION (City, town, or county) (State): Balto. Md.
23. FUNERAL DIRECTOR'S SIGNATURE: William Keene
ADDRESS
24a. REC'D BY REGISTRAR DATE MAR 5 '59
24b. REGISTRAR'S SIGNATURE: Irving S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02596

2599 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ANNE Arundel Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 42 Lafayette Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First BENJAMIN Middle Brown Last
4. DATE OF DEATH: Month MAR Day 20 Year 1959

5. SEX: M
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 9-1888
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS: Months | Days | Hours | Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dairy Co. Laborer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Anne Arundel Co.
12. CITIZEN OF WHAT COUNTRY? Md.

13. FATHER'S NAME: DANIEL Brown
14. MOTHER'S MAIDEN NAME: Mariah Little

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): UNKNOWN
16. SOCIAL SECURITY NO: 218-12-9388-A
INFORMANT: Annie B. Johns
Address: ANNAPOLIS-Md. 42 Lafayette Ave

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Hemorrhage
331X
DUE TO (b): Uremia & chronic Hypertension
DUE TO (c): Coronary disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)
20c. TIME OF INJURY Hour a. m. p m Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 20, 1959 to March 20, 1959 that I last saw the deceased alive on March 20, 1959, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. B. Richardson M.D. ADDRESS (Street, city or town, state): 110 Clay St Annapolis, Md. DATE SIGNED: 3/23/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3-24-59
22c. NAME OF CEMETERY OR CREMATORY: Brewer-Hill
22d. LOCATION (City, town, or county) (State): ANNAPOLIS Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles F. Hicks III ADDRESS: Annapolis Md.
24a. REC'D BY REGISTRAR DATE: MAR 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2644 **CERTIFICATE OF DEATH** 02597

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ventor Md.
c. LENGTH OF STAY IN 1b: 6 Mths.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Ventor Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ventor Md.
d. STREET ADDRESS: 1 Ventor Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle HAMILTON Last BROWN
4. DATE OF DEATH: Month MARCH Day 31 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-23-1883
9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caretaker
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Woodensburg, Balto, Co.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Samuel H. Brown
14. MOTHER'S MAIDEN NAME: Mart Melching
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 217-03-3545
17. INFORMANT: Alice May Brown — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	CEREBRAL HEMORRHAGE	2 HOURS
443X DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — (b)	HYPERTENSIVE CARDIOVASCULAR DISEASE	5 YEARS
DUE TO (c)		

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year; Hour o. m. p. m.; 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from DEC. 18, 1958 to MARCH 31, 1959, that I last saw the deceased alive on MARCH 30, 1959, and that death occurred at 6:00A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Brady Smith M D — ADDRESS (Street, city or town, state): Riviera Beach — DATE SIGNED: 3/31/59
PHYSICIAN'S NAME (Type): J. BRADY SMITH — Pasadena, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-2-59
22c. NAME OF CEMETERY OR CREMATORY: Meadowridge
22d. LOCATION (City, town, or county) (State): Washington Rd. Dorsey Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Frank H. Hurd Gibsonville S. Md.
24a. REC'D BY REGISTRAR DATE: APR 3 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2645 Item 1 Finished 3-30-59 et

CERTIFICATE OF DEATH

02599

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
c. LENGTH OF STAY IN 1b: 5 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Daughter's home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: N. J. — b. COUNTY: Bergen
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Saddle River
d. STREET ADDRESS: 44 Lake Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: — Last: Butscher

4. DATE OF DEATH: Month: 3 — Day: 20 — Year: 1959

5. SEX: M.

6. COLOR OR RACE: W.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 6, 1872

9. AGE (In years last birthday): 86 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York City

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Otto Butscher,

14. MOTHER'S MAIDEN NAME: Louise Gumpert,

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Sherwood H. Butscher (Son)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)	Cardiac failure	6 days
DUE TO	443 X	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Hypertensive cardiovascular disease	3 months
DUE TO (c)	and carcinoma of prostate	2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month — Day — Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 3, 1959, to March, 1959, that I last saw the deceased alive on March 20, 1959, and that death occurred at 5:40 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Sylvia M. Lim M.D. — ADDRESS (Street, city or town, state): RFD #1 Box 277-M — DATE SIGNED: 3-20-59

PHYSICIAN'S NAME (Type): Sylvia M. Lim, M.D. — Edgewater, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 3-23-59

22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemt

22d. LOCATION (City, town, or county): Prince George Co (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR — DATE: MAR 24 '59

24b. REGISTRAR'S SIGNATURE: Arthur J. Howe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 Hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A1SC 1-58 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02600

CERTIFICATE OF DEATH

2646 Item 5, see birth Cert. et

Reg. Dist. No. 27

1. PLACE OF DEATH

COUNTY: Anne Arundel — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade

LENGTH OF STAY (In this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S.Army Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland COUNTY: Anne Arundel

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft George G. Meade

STREET ADDRESS (If rural give location): Bldg 2365 Apt A

3. NAME OF [redacted] (Type or Print): (First) Frank (Middle) Gerard (Last) Carr Twin II

4. DATE OF DEATH (Month) March (Day) 7 (Year) 1959

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cau	[redacted]	5 March 1959	yrs.		2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant	-	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Perry Carr	Marie Tieyah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	-	Hospital Records U.S.Army Hosp, Ft Meade, Md

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

77/x IMMEDIATE CAUSE (A) Prematurity — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5 March, 1959, to 7 March, 1959, that I last saw the deceased alive on 7 March, 1959, and that death occurred at 1145AM, from the causes and on the date stated above.

SIGNATURE [redacted] M.D. ADDRESS (Street, city, town, state): U.S.Army Hosp, Ft Meade, Md DATE SIGNED: 7 Mar 59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Cremation	9 March 59	Laboratory U.S.Army Hospital	Ft G. G. Meade, Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
MAR 12 '59	Clifton L Kruse	[redacted]	U.S.Army Hosp, Ft Meade, Md

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 5, Birth Cert. of

2647

02601

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort George G. Meade, Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U. S. Army Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Fort George G. Meade,
d. STREET ADDRESS: Bldg 2365 Apt A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Norma — Middle: Jean — Twin I Carr

4. DATE OF DEATH: Month: March — Day: 6 — Year: 19 59

5. SEX: Female
6. COLOR OR RACE: Cau
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5 March 1959
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours: 27 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Perry Carr
14. MOTHER'S MAIDEN NAME: Marie Tieyah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Father — Address: Bldg 2365 Apt A, Ft George G. Meade, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Lung disease-possible hyaline membrane disease — INTERVAL BETWEEN ONSET AND DEATH: 27 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Prematurity
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5 March 59, to 6 March 59, that I last saw the deceased alive on 6 March 59, and that death occurred at 8:10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Fred W Lafferty, M.D. — ADDRESS (Street, city or town, state): US Army H SP, Ft Geo G Meade, Md — DATE SIGNED: 6 Mar 59

PHYSICIAN'S NAME (Type): FRED W. LAFFERTY Capt., MC

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 6 March 59
22c. NAME OF CEMETERY OR CREMATORY: U.S.Army Hosp(Laboratory)
22d. LOCATION (City, town, or county) (State): Ft George G. Meade, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Chaplain Capt USA — ADDRESS: USAH Fort Geo G Meade Md

24a. REC'D BY REGISTRAR DATE: MAR 12 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Kraus

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02602

2648

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MILLERSVILLE
c. LENGTH OF STAY IN 1b: 1 mos

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MD
b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 7 COLONIAL AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SANN'S NURSING HOME

3. NAME OF DECEASED (Type or print): First ELLA Middle M. Last CASTLES

4. DATE OF DEATH: Month 3 Day 10 Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11-20-1875
9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: [illegible] BISHOP
14. MOTHER'S MAIDEN NAME: [illegible] WAGATE, Amanda

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO: none
INFORMANT: Mary Neuberger — Address: [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 490X — Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Lobar Pneumonia — 1 week
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Thrombosis — 6 months
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-27-59, 19__, to March 10-59, 19__, that I last saw the deceased alive on 3-9-59, 19__, and that death occurred at 2:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): Edenton Md — DATE SIGNED
PHYSICIAN'S NAME (Type): DR. JOSEPH LIPSKY — Edenton, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-13-59
22c. NAME OF CEMETERY OR CREMATORY: West Laurel Hill Cemt
22d. LOCATION (City, town, or county): Phila. (State): Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: MAR 12 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02603

2649 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dill Rd
c. LENGTH OF STAY IN IS 9 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Severna Park

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Md
b. COUNTY An. Md
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park
d. STREET ADDRESS Dill Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First George Middle John Last Clark

4. DATE OF DEATH Month 3 Day 3 Year 59 19

5. SEX M
6. COLOR OR RACE Wi
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 6d 31 1885
9. AGE (In years last birthday) 73 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist
10b. KIND OF BUSINESS OR INDUSTRY Soap
11. BIRTHPLACE (State or foreign country) Roxanna Md
12. CITIZEN OF WHAT COUNTRY U.S.

13. FATHER'S NAME Cyrus Clark
14. MOTHER'S MAIDEN NAME Mc Elvin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b) Acute Myocardial Infarction
DUE TO (c) Gen-Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that I attended the deceased from 12-5-58, 19____, to ____, 19____, that I last saw the deceased alive on Feb 25 19____, and that death occurred at 10 3/4 A.M., from the causes and on the date stated above

ACTUAL SIGNATURE Robert R Hahn MD
ADDRESS (Street, city or town, state) Severna Park
DATE SIGNED
PHYSICIAN'S NAME (Type) Robert B. HAHN
md 3-3-59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3/6/59
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill
22d. LOCATION (City, town, or county) Anne Arundel (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE T P Singleton
ADDRESS Glen Burnie Md.

24a. REC'D BY REGISTRAR DATE MAR 5 '59
24b. REGISTRAR'S SIGNATURE Elaine B Hayes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be detached by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2650 **CERTIFICATE OF DEATH** 02604

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A.A.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md b. COUNTY: A.A.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn.

c. LENGTH OF STAY IN 1b: 50

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 206 Hanover Rd

d STREET ADDRESS: 206 Hanover Rd

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Clarence Middle: L. Last: Clayton, Jr.

4. DATE OF DEATH: Month: 3-1-59. Day: Year: 19

5. SEX: M.

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/8/98.

9 AGE (In years last birthday): 60 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fire fighter

10b. KIND OF BUSINESS OR INDUSTRY: B C F D.

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James.

14. MOTHER'S MAIDEN NAME: Margaret O'Brien

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Family - Same Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 28 Feb 59

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) A.S.C.V.D. & Pulm. Emphysema & Fibrosis — 1 Mar 59

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr, 1957, to March, 1959, that I last saw the deceased alive on 28 Feb 59, 19, and that death occurred at 1:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Andrew R Sosnowski M.D. ADDRESS (Street, city or town, state): 4016 Ritchie Hiway Baltimore 2 Md DATE SIGNED: 2 Mar 59

PHYSICIAN'S NAME (Type): Andrew R. Sosnowski M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): B

22b DATE THEREOF: 3/4/59.

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill

22d LOCATION (City, town, or county) (State): Balto.

23. FUNERAL DIRECTOR'S SIGNATURE: McCleary ADDRESS: Funeral Home 130 E. Fort Ave.

24a. REC'D BY REGISTRAR DATE: MAR 4 '59

24b REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2651 Item 1 Reg. 2209 1-16-59 et

CERTIFICATE OF DEATH

02605 Reg. Dist. No.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lothian
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Moreland Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md.
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgemere Shores
d. STREET ADDRESS: Box 256 R.7 D.3 Annapolis Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Clarence Middle Lee Last Cowles

4. DATE OF DEATH: Month Mar Day 6 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-4-1872
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt of Schools
10b. KIND OF BUSINESS OR INDUSTRY: Supt of Schools
11. BIRTHPLACE (State or foreign country): Vermont
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Lee Cowles
14. MOTHER'S MAIDEN NAME: Mary Whitney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT (Address): William D. Husted (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): generalized arteriosclerosis

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fractured hip (old). — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept --, 1957, to March 6, 1959, that I last saw the deceased alive on Mar. --, 1959, and that death occurred at 2 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Emily H. Wilson M.D. — ADDRESS (Street, city or town, state): Lothian Md — DATE SIGNED: 3-6-59

PHYSICIAN'S NAME (Type): EMILY H WILSON

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 3-7-59
22c. NAME OF CEMETERY OR CREMATORY
22d. LOCATION (City, town, or county): Strasburg (State) Va

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Saylor Sons — ADDRESS: Annapolis Md.
24a. REC'D BY REGISTRAR DATE MAR 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2600 CERTIFICATE OF DEATH

Reg. Dist. No. 02606

1 PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 823 Spa Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Annapolis
d. STREET ADDRESS 823 Spa Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Elizabeth Middle C. Last Creek

4 DATE OF DEATH Month 3 Day 14 Year 1959

5 SEX Female
6. COLOR OR RACE Col.
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 3-27-1872
9. AGE (In years last birthday) 86 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) A.A. Co. Md.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME John Hawkins
14 MOTHER'S MAIDEN NAME Priscilla Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) No If yes, give war or dates of service
16. SOCIAL SECURITY NO. —
INFORMANT Nannie Creek — Address Annapolis Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Congestive Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH 2 days
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-14-59, 19___, to 3-14-59, 19___, that I last saw the deceased alive on 3-14-59, 19___, and that death occurred at 12:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE A. T. Allen M.D. ADDRESS (Street, city or town, state) 42 Cathedral St DATE SIGNED 3-14-59
PHYSICIAN'S NAME (Type) A. T. ALLEN Annapolis Md.

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF 3-18-59
22c NAME OF CEMETERY OR CREMATORY Brewer Hill
22d LOCATION (City, town, or county) (State) Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE William Reese II ADDRESS Ann'p. Md
24a. REC'D BY REGISTRAR DATE MAR 18 '59
24b. REGISTRAR'S SIGNATURE Lorman L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 and the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02607

CERTIFICATE OF DEATH

2601 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 16 days
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Galesville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First William Middle Last Crowner

4. DATE OF DEATH: Month March Day 26 Year 1959

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH:
9. AGE (In years last birthday) 77 yrs
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME
14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT: Mrs. Ruth Crowner Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Renal Insufficiency Due to
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Hypertension
DUE TO (c): Vascular disease
446 X
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 10, 1959 to March 26, 1959, that I last saw the deceased alive on March 26, 1959, and that death occurred at 2:40 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R. C. Richardson M.D. ADDRESS (Street, city or town, state): 110 - CLAY ST ANNAPOLIS, MD. DATE SIGNED: 3/30/59
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-31-59
22c. NAME OF CEMETERY OR CREMATORY: Crownsville Memorial Park
22d. LOCATION (City, town, or county) Galesville (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: [illegible] Annapolis, Md.
24a. REC'D BY REGISTRAR DATE MAR 31 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02608

2602

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 107 Clay St.

2 USUAL RESIDENCE (Where deceased lived. If inst tution-Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 107 Clay St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First John — Middle E — Last Davis

4. DATE OF DEATH: Month 3 — Day 2 — Year 1959

5 SEX: Male

6 COLOR OR RACE: Col.

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 7-4-1894

9 AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months 7 — Days 28
IF UNDER 24 HRS: Hours — Min

10a (GIVE) OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b KIND OF BUSINESS OR INDUSTRY: U.S. Naval Academy

11 BIRTHPLACE (State or foreign country): East Port, Md.

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Virgil Davis

14 MOTHER'S MAIDEN NAME: Mary Peel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): 1 to WW I

16. SOCIAL SECURITY NO.:

INFORMANT: Jessie Davis — Address: Annapolis, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis
DUE TO (b): Coronary artery disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

420.1

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1958 to March 2, 1959 that I last saw the deceased alive on March 2, 1959, and that death occurred at 1:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R.L. Pechar dmd M.D. — ADDRESS (Street, city or town, state): 110 Clay STREET ANNAPOLIS MD — DATE SIGNED: 3/2/59

PHYSICIAN'S NAME (Type):

22a BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 3-5-59 — 22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill — 22d. LOCATION (City, town, or county): Annapolis, Md. (State)

23 FUNERAL DIRECTOR'S SIGNATURE: William Reese, Jr. — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: MAR 3 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Moore

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2603

CERTIFICATE OF DEATH

Reg. Dist. No. 02609

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewater
d. STREET ADDRESS: Box 337
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: MICHAEL — Middle: — Last: Dawson

4 DATE OF DEATH: Month: March — Day: 4 — Year: 1959

5 SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: March 4, 1959

9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: 3 — Min.: 30

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11 BIRTHPLACE (State or foreign country): Annapolis, Md.

12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Donald Stewart Dawson

14. MOTHER'S MAIDEN NAME: Dora Antoinette Koogle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — — —
(If yes, give war or dates of service) — — —

16. SOCIAL SECURITY NO. — — — — —

INFORMANT: Mother — Address: Box 337, Edgewater, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 5 hours

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 3-4-59, 19___, to 3-4-59, 19___, that I last saw the deceased alive on 3-4-59 19___, and that death occurred at 11 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Albert L. Anderson M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type): Albert L. Anderson MD — 44 Southgate Ave. Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b DATE THEREOF: March 5, 1959

22c. NAME OF CEMETERY OR CREMATORY: Mayo Memorial Cemetery

22d LOCATION (City, town, or county) (State): Mayo, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: HOPPING FUNERAL HOME Annapolis, Maryland

24a. REC'D BY REGISTRAR — DATE: MAR 9 '59

24b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2604 — Reg. Dist. No. — 02610

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 only should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/[illegible]5

1. PLACE OF DEATH — a. COUNTY: a a. — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Md — b. COUNTY: a a.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis — c. LENGTH OF STAY IN 1b
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: a.a. General Hospital — d. STREET ADDRESS: 1214 Grant St — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Milton — Middle: — Last: Dawson
4. DATE OF DEATH: Month: 3 — Day: 30 — Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 19-1874
9. AGE (In years last birthday): 84 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman Crab Fish
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Mayo Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A
13. FATHER'S NAME: Joseph I. Dawson
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Enola L Dawson (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia, Left Lung — Time
470X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 25 19 59 to March 30 19 59, that I last saw the deceased alive on March 30, 19 59, and that death occurred at 10 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: John C Hodson M.D. — ADDRESS (Street, city or town, state): 121 Cathedral — DATE SIGNED: 3/31/59

PHYSICIAN'S NAME (Type): [illegible]

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-1-59
22c. NAME OF CEMETERY OR CREMATORY: Mayo Memorial
22d. LOCATION (City, town, or county): Mayo (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR — DATE: APR 2 '59
24b. REGISTRAR'S SIGNATURE: Clinton L. Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2605

Reg. Dist. No. 02611

1. PLACE OF DEATH
a. COUNTY: Aa — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A.A. General

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Md.
b. COUNTY: Aa
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 800 Boucher Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Susan Middle A. Lost Defenbaugh

4. DATE OF DEATH: Month 3 Day 6 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept 5th 1876

9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Cambridge Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Sarah Dail

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT (Address): Mrs Russell E. Hallock (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident 3/4/59 — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Thrombosis? Hemorrhage? cerebral
DUE TO (c): senility changes - fractured left hip

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): aged - senile changes — cerebrovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fall in her home fractured left hip

20c. TIME OF INJURY Hour 3:30 a.m. p.m. Month, Day, Year 2-24 1959

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Annapolis Anne Arundel Md

21. I certify that I attended the deceased from Feb 24, 1959, to March 6, 1959, that I last saw the deceased alive on March 6, 1959, and that death occurred at 4:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Harold R. Bohlman M.D. — ADDRESS (Street, city or town, state): 96 Cathedral St. Annapolis Md — DATE SIGNED: 3/9/59

PHYSICIAN'S NAME (Type): Harold R. Bohlman MD 96 Cathedral St " 3/9/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-9-59
22c. NAME OF CEMETERY OR CREMATORY: Edwards Chapel
22d. LOCATION (City, town, or county) (State): Parole Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR DATE: MAR 11 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kuhn

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02612

2606

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A.A.General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pasadena
d. STREET ADDRESS: Route 5, Box 61
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Rena — Middle: L. — Last: Despeaux
4. DATE OF DEATH: Month: March — Day: 29 — Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: August 6, 1891
9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Practical Nurse
10b. KIND OF BUSINESS OR INDUSTRY: State Hospital
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Walter Crawford
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 217-22-0476
17. INFORMANT — Address: Charles Despeaux, Jr., Rt. 5, Box 61, Pasadena, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)	Cerebral hemorrhage	10 months
331X DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Hypertensive vascular disease	10 years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to March 29, 1959, that I last saw the deceased alive on March 29, 1959, and that death occurred at 1:35 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward S. Beck M D
ADDRESS (Street, city or town, state): 41 Southgate Avenue
DATE SIGNED: 3-29-59
PHYSICIAN'S NAME (Type): Edward S. Beck — Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
BURIAL	4-2-59	Loudon Park Cemetery	Baltimore

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS	24a. REC'D BY REGISTRAR DATE	24b REGISTRAR'S SIGNATURE
William Cook, Inc., 1217 St. Paul Street	APR 3 '59	Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02613

2652 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton
c. LENGTH OF STAY IN 1b 10 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Annapolis Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton
d. STREET ADDRESS Annapolis Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Andrew Middle J. Last Disney Jr.
4. DATE OF DEATH Month March Day 28th Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Dec. 21- 1872
9. AGE (In years last birthday) 86 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmiths-Helper
10b. KIND OF BUSINESS OR INDUSTRY B & A R.R.
11. BIRTHPLACE (State or foreign country) Anne Arundel Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Andrew J. Disney - Sr.
14. MOTHER'S MAIDEN NAME Harriett V. Rodmiles
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Kenneth L. Disney Address Sameas No 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 1 day
DUE TO (b) Arteriosclerosis — 1 yr
DUE TO (c) —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. H22.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 25 19 24, to March 28 19 59, that I last saw the deceased alive on March 26 19 59, and that death occurred at 5 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE Joseph Lipsky M.D. ADDRESS (Street, city or town, state) Odenton, Md. DATE SIGNED 3-31-59
PHYSICIAN'S NAME (Type) JOSEPH LIPSKY

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3/31/59
22c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery
22d. LOCATION (City, town, or county) Anne Arundel (State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
24a. REC'D BY REGISTRAR DATE APR 1 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02614

CERTIFICATE OF DEATH

2607 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ANNE ARUNDEL GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X GAMBRILLS
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First FRANCES Middle Last DOLJAN

4. DATE OF DEATH: Month MARCH Day 11 Year 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Sept. 16, 1881
9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mr. Joseph Doljan Jr Son Address: Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Cardio Vascular — DUE TO
(c): Senile — yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m., 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar 4, 19 59 to March 11, 1959 that I last saw the deceased alive on March 11, 1959, and that death occurred at 11 30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Maurice F Klawans M.D
ADDRESS (Street, city or town, state): 31 Southgate Ave. Annapolis, Md.
DATE SIGNED: March 12, 1959
PHYSICIAN'S NAME (Type): Maurice F. Klawans MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-14-1959
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Hoppin's Funeral Home
ADDRESS: Annapolis, Maryland
24a. REC'D BY REGISTRAR: DATE MAR 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

n2613

2653 Item 4 Film G239 3-15-59 et

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY ANNE ARUNDEL MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE

LENGTH OF STAY (in this place) 3 months

HOSPITAL OR INSTITUTION OR STREET ADDRESS 204 CARROLL Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MARYLAND COUNTY

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE

STREET (If rural give location) 419 S. BENTALOU ST.

3. NAME OF DECEASED (Type or Print) (First) LOLA (Middle) GERTRUDE (Last) DORSEY

4. DATE OF DEATH (Month) March (Day) 8, (Year) 19 59

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min.
FEMALE	WHITE	Widowed	JANUARY 12, 1883	76 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
HOUSEWIFE	DOMESTIC	VIRGINIA	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DOUGLAS MARTIN	MARGARET JOHNSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
NO	NONE	NONE	ALMER DORSEY 419 S. BENTALOU ST.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1 X IMMEDIATE CAUSE (A) Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH 4 Months

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21a. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/20, 1958, to 3/8, 1959, that I last saw the deceased alive on 3/4/59, 1959, and that death occurred at 11 A.M, from the causes and on the date stated above.

SIGNATURE Paul Schofield M.D. ADDRESS (Street, city, town, state) 801 Arlington Rd DATE SIGNED 3/9/59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	3/11/59	WOODLAWN	WOODLAWN Md

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS
MAR 11 '59	Arthur E. Krause	GEO. L. Schwab Funeral Home (Barbara M. Schwab 2101 Frederick Ave

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2654

CERTIFICATE OF DEATH

02616
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riva
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Riva Nursing Home

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arnold
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RUODA Middle Last DULL
4. DATE OF DEATH: Month March Day 4 Year 1959

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 4, 1878
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Waynesborough, Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SIRAS BROWN
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): — — — — —
16. SOCIAL SECURITY NO.: — — — —
17. INFORMANT: Mr Curty Dull Sr- Son
Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 60 Hours

DUE TO (b): GENERALIZED ARTERIOSCLEROSIS — Unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 15 Jan, 1959, to 4 March, 1959, that I last saw the deceased alive on 3 MAR, 1959, and that death occurred at 11 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward A Beck M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED:

PHYSICIAN'S NAME (Type): EDWARD S BECK, M.D., 41 Southgate Ave, Annapolis, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 7, 1959
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff
22d LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME
ADDRESS: Annapolis, Maryland 172 West St
24a. REC'D BY REGISTRAR: DATE MAR 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02617

Reg. Dist. No. 2608

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 4 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII. AISME
8M 2/57

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ANNE ARUNDEL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X EDGEWATER
d. STREET ADDRESS: Mt Stewart Farm
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JAMES — Middle RINGGOLD — Last DUVALL
4. DATE OF DEATH: Month MARCH — Day 27 — Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Feb.17,1895
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caretaker
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Edgewater, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: RINGGOLD DUVALL
14. MOTHER'S MAIDEN NAME: MARY WILLARD

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: none
17. INFORMANT: E.Saunders Duvall- Brother- Address 9 Steele Ave. Annapolis, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 1-2-3rd Burns 60% Body —
INTERVAL BETWEEN ONSET AND DEATH: 9 days.
916.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonic Embolism.

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): attempting to put out brush fire.
20c. TIME OF INJURY: Hour — p. m. — Month, Day, Year: 3-19-1959
20d. INJURY OCCURRED: While at work [ ] Not while at work [X]
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [ ]. Accident [X]. Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: [signature] M.D
EXAMINER'S NAME (Type): Elmer G. Linhardt MD
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
DATE SIGNED: 3/31/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: March 30, 1959
22c. NAME OF CEMETERY OR CREMATORY: Salem Cemetery
22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: HOPPING FUNERAL HOME Annapolis, Md.

24a REC'D BY REGISTRAR DATE: APR 1 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2655

CERTIFICATE OF DEATH

02618

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft. Geo. G. Meade
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USAH Ft Geo. G. Meade, Md

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Severn
d. STREET ADDRESS: 425 Thompson Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First (Infant) Donald — Middle R. — Last Engle

4. DATE OF DEATH: Month March — Day 24 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 24 March 1959

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 7 — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Donald R Engle

14. MOTHER'S MAIDEN NAME: Patricia J. Stuckey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Donald R. Engle, 425 Thompson Ave, Severn, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
DUE TO: Microagnathia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Pierre Robin Syndrome – Cleft Palate
DUE TO: Glossoptosis
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 24 March, 1959, to 24 March, 1959, that I last saw the deceased alive on 24 March, 1959, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Fred W. Lafferty M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: 3/24/59

PHYSICIAN'S NAME (Type): FREDERICK W LAFFERTY Captain MC — U. S. ARMY HOSPITAL, FT MEADE, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

22b. DATE THEREOF: 3-27-59

22c. NAME OF CEMETERY OR CREMATORY: Springfield Cemetery

22d. LOCATION (City, town, or county) (State): Springfield, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: William Cook, Inc., 1217 St. Paul Strett

24a. REC'D BY REGISTRAR DATE: MAR 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Howe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2609 **CERTIFICATE OF DEATH**

Reg. Dist. No. 02619

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 10

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 415 Chester Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Anne Arundel General Hospital

3. NAME OF DECEASED (Type or print): First — Middle — Last: Forrester

4. DATE OF DEATH: Month: March; Day: 18; Year: 1959

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 18, 1959

9. AGE (In years last birthday) yrs

IF UNDER 1 YEAR: Months; Days: 10

IF UNDER 24 HRS: Hours; Min.: 55

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bernard Albert Forrester

14. MOTHER'S MAIDEN NAME: Doris Pauline Booth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT — Address: Mother, 415 Chester Ave., Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs 55 m
DUE TO
(b):
DUE TO
(c):

776X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 18, 1959, to March 18, 1959, that I last saw the deceased alive on March 18, 1959, and that death occurred at 1:45 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Neil H. Lamm M.D. — ADDRESS (Street, city or town, state): 95 Cathedral St. Annapolis, Md. — DATE SIGNED: 3/24/59

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-24-59

22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

22d. LOCATION (City, town, or county): Annapolis (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm Reese #.108 Wash St. — ADDRESS: Anna Md

24a. REC'D BY REGISTRAR — DATE: MAR 26 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
TSM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2610 **CERTIFICATE OF DEATH** 02620

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: a a — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSP. (If not in hospital, give street address) OR INSTITUTION: a a General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: a a
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 41 Murray Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Clarence Middle E. Last Fouche
4. DATE OF DEATH: Month MARCH Day 6 Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 14th 1885
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10b. KIND OF BUSINESS OR INDUSTRY: Plumber
11. BIRTHPLACE (State or foreign country): Annapolis Md
12. CITIZEN OF WHAT COUNTRY? U-S-A
13. FATHER'S NAME: John R. Fouche
14. MOTHER'S MAIDEN NAME: Annie R. Medford
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Ella M. Fouche (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary artery atherosclerosis — 5 yrs
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Renal lithiasis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that I last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] M, from the causes and on the date stated above.
ACTUAL SIGNATURE: John R. Hedrick M.D. ADDRESS (Street, city or town, state): 21 Cornhill St DATE SIGNED: 3/6/57
PHYSICIAN'S NAME (Type): Annapolis Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-9-59
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
22d. LOCATION (City, town, or county): Annapolis (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Naylor Sons ADDRESS: Annapolis Md.
24c. REC'D BY REGISTRAR DATE: MAR 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Rivara

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02621

2656

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 2mo 10days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First William — Middle — Last Fountain

4. DATE OF DEATH: Month 3 — Day 4 — Year 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1880

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 214-10-0613

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Inanition and Dehydration — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Post Surgical — Intestinal Obstruction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Inter Trochanteric Fracture Right Hip

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Tuberculosis — Senility — Syphilis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. ---- 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---

20f. (City or town) (County) (State) ---

21. I certify that I attended the deceased from 12/24, 1958 to 3/4/59, 19..., that I last saw the deceased alive on 3/4/59, 19 59 and that death occurred at 10:30P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 3/5/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.
Crownsville State Hospital, Md. 3/5/59

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: March 7/59
22c. NAME OF CEMETERY OR CREMATORY: Easton Cemetery
22d. LOCATION (City, town, or county) (State): Easton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. F. Moore & Son
ADDRESS: Easton Md

24a. REC'D BY REGISTRAR
DATE MAR 13 '59

24b. REGISTRAR'S SIGNATURE: Arthur E. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02622

2611

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/SS

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 129 Monticello Ave

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 129 Monticello Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William Middle: Henry Last: French
4. DATE OF DEATH: Month: 3 Day: 6 Year: 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec 21-1894
9. AGE (In years last birthday): 64 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mgr. Circulation Dept.
10b. KIND OF BUSINESS OR INDUSTRY: Newspaper Business
11. BIRTHPLACE (State or foreign country): Norfolk Va
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: William N. French
14. MOTHER'S MAIDEN NAME: Minnie Woolhiser
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes — If yes, give war or dates of service: World War I
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Lillie L. French — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	MYOCARDIAL INFARCTION	1 HOUR
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	CORONARY THROMBOSIS	1 HOUR
DUE TO (c)	ARTERIOSCLEROTIC CORONARY ART. DIS.	UNKNOWN

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): HYPERTENSION, MODERATE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/16, 1959, to 3/6, 1959, that I last saw the deceased alive on 3/2, 1959, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward S Beck M.D. ADDRESS (Street, city or town, state): 41 Southgate AVE DATE SIGNED: 3/7/59

PHYSICIAN'S NAME (Type): EDWARD S. BECK MD ANNAPOLIS, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar-9-59
22c. NAME OF CEMETERY OR CREMATORY: Cedar Grove
22d. LOCATION (City, town, or county) (State): Norfolk Va

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Layton Sons ADDRESS: Annapolis Md.
24a. REC'D BY REGISTRAR DATE: MAR 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2657

CERTIFICATE OF DEATH

02623

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 29yrs.2m6.10d
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore,
d. STREET ADDRESS: 826 Tessier Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Ida; Middle: ; Last: Gabriel

4. DATE OF DEATH: Month: 3; Day: 20; Year: 1959

5 SEX: Female

6 COLOR OR RACE: Negro

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1882

9. AGE (In years last birthday): 77 yrs

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Houseworker

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: John Cole

14. MOTHER'S MAIDEN NAME: Sarah

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Senile Atrophy — INTERVAL BETWEEN ONSET AND DEATH:

M.D.

DUE TO (b): Generalized Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cellulitis of the Right Hand

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ---

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. ---- 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---

20f. (City or town) (County) (State): ---

21. I certify that I attended the deceased from 1/10 1930 to 3/20 1959 that I last saw the deceased alive on 3/20 1959, and that death occurred at 12:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: L. Benedict M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 3/20/59

PHYSICIAN'S NAME (Type): L. Benedict, M. D. — Crownsville State Hospital, Md. 3/20/59

22a BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 3-26-59

22c. ~~NAME OF CEMETERY OR CREMATORY~~: Anatomy Board of Md.

22d LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Harry Reese II — ADDRESS:

24a REC'D BY REGISTRAR DATE: APR 2 '59

24b REGISTRAR'S SIGNATURE: Arthur L. Mans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2612

CERTIFICATE OF DEATH

02624
Reg. Dist. No

1 PLACE OF DEATH
a. COUNTY: A A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): A. G. General Hospital

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: Arundel Road R.D. #3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Helen Middle Bain Last Gray

4. DATE OF DEATH: Month 3 Day 29 Year 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 29-1900
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Scotland
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Robert Bain
14 MOTHER'S MAIDEN NAME: Helen Seth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16 SOCIAL SECURITY NO
17 INFORMANT: John Gray Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
199.2
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 1959, to March 1959, that I last saw the deceased alive on March 21, 1959, and that death occurred at 12:55 M, from the causes ond on the date stated abave.

ACTUAL SIGNATURE: John A. Workman M.D — ADDRESS (Street, city or town, state): 121 Cathedral St. — DATE SIGNED: 3/31/59
PHYSICIAN'S NAME (Type): Carroll A Wolf

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Apr 1-59
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemt.
22d. LOCATION (City, town, or county): Annapolis (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: APR 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2613 — Reg. Dist. No. 02626

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 513 1st St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: A.A. Co.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
d. STREET ADDRESS: 33 EASTERN AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SUSAN — Middle K. — Last HANCOCK
4. DATE OF DEATH: Month 3 — Day 27 — Year 1959
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3-28-1881
9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (State or foreign country): KENTUCKY
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ANDREW J. MEUTH
14. MOTHER'S MAIDEN NAME: KATHERINE HOOVER
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO:
17. INFORMANT: WALTER HANCOCK — Address #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CARCINOMA — INTERVAL BETWEEN ONSET AND DEATH: 3 days
4 mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROTIC HEART DISEASE — 17 yrs.
DUE TO (c):
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 4, 19 59 to Mar. 27, 19 59, that I last saw the deceased alive on 3-27-59, 19 59, and that death occurred at 5:30 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: James R. Martin, M.D. — ADDRESS (Street, city or town, state): 63 Hilltop St. Annapolis, Md. — DATE SIGNED: 3/27/59
PHYSICIAN'S NAME (Type): JAMES R. MARTIN

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3-29-59
22c. NAME OF CEMETERY OR CREMATORY: CEDAR BLUFF
22d. LOCATION (City, town, or county): ANNAPOLIS (State): MD.
23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis, Md.
24a. REC'D BY REGISTRAR DATE: MAR 30 '59
24b. REGISTRAR'S SIGNATURE: Carlton S. Hines

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2614 CERTIFICATE OF DEATH

02627
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Aa — MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: Md. b. COUNTY: Aa
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 48 Franklin St
d. STREET ADDRESS: 48 Franklin
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Jeanne Middle: J. Last: Herron
4. DATE OF DEATH: Month: 3 Day: 3 Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 21-1908
9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Elmer Martin Jackson Sr.
14. MOTHER'S MAIDEN NAME: Blanche Beatrice Bower
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Robert J. Herron Address (2)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute coronary heart disease	
DUE TO (b)	cardiac strain	10 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Myocardial ?	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-29-56 19[illegible] to 3-3 19[illegible], that I last saw the deceased alive on 2-16 19[illegible], and that death occurred at 2[illegible] M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Edith Rodier M.D. M.D. ADDRESS (Street, city or town, state): 45 Franklin St. Annapolis Md. DATE SIGNED: 3-5-59
PHYSICIAN'S NAME (Type): EDITH RODIER M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-6-59
22c. NAME OF CEMETERY OR CREMATORY: Mount Academy Cemt
22d. LOCATION (City, town, or county): Annapolis (State): Md
23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: MAR 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krome

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02628

Reg. Dist. No. 2615

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 917 West St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, Md.
d. STREET ADDRESS: 917 West St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Michael — Middle: John — Last: Holland

4. DATE OF DEATH: Month: 3 — Day: 8 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-2-1955

9. AGE (In years last birthday): 4 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Holland

14. MOTHER'S MAIDEN NAME: Adele Randall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: John Holland — Address: Annapolis, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Burns - Generalized — INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO (b): 946.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Home Fire

20c. TIME OF INJURY: Hour a m / p m — Month, Day, Year: 3/8/59

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Ann. Ard. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): F. Linhardt

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3/10/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-11-59
22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill
22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese, Jr. — ADDRESS: Annap. Md.

24a. REC'D BY REGISTRAR — DATE: MAR 10 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Hance

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2616

CERTIFICATE OF DEATH

02629

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANNAPOLIS
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. A. General Hospt.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Severn
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairmount
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NELLIE Middle Last HOLLAND

4. DATE OF DEATH: Month 3 Day 19 Year 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug 21 1880

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Revells

14. MOTHER'S MAIDEN NAME: Nancy Mariner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Name Hallard Address Pr. Anne Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): ARTERIOSCLEROSIS, GENERALIZED — unknown
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROTIC HEART DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1953, to 19 MAR., 1959, that I last saw the deceased alive on 18 MAR 1959, and that death occurred at 2:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward L. Beck M.D. — ADDRESS (Street, city or town, state): 41 Southgate Ave. — DATE SIGNED: 3/19/59

PHYSICIAN'S NAME (Type): Annapolis MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-22-59

22c. NAME OF CEMETERY OR CREMATORY: St. Andrews Cem

22d. LOCATION (City, town, or county) (State): Princess Anne Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Leon R. Wilson — ADDRESS: Princess Anne Md

24a. REC'D BY REGISTRAR DATE: MAR 23 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02630

2658 Item 7 Film 240 3-20-59 et

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME 5M 2 '57

1. PLACE OF DEATH — COUNTY: Anne Arundel — STATE: MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) — STATE: Same — b. COUNTY: Same

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): P.O. Glen Burnie

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 1, Box 213, Lombardee Beach

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Frank — Middle D. — Last Hustak

4. DATE OF DEATH: Month March — Day 15th. — Year 1959

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APRIL 17

9. AGE (In years last birthday): 77 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired labor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: FRANK HUSTAK

14. MOTHER'S MAIDEN NAME: ANNA MATEJKA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212 01 2701

17. INFORMANT — Address: MARY SVEHLA, 909 N. COLLINGTON AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

DUE TO (b): General Arteriosclerosis — ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour — a. m. p. m. — Month, Day, Year — 19

20d. INJURY OCCURRED — While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert M.D. — M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 3/15/59

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3-18-59

22c. NAME OF CEMETERY OR CREMATORY: BOHEMIAN NATIONAL

22d. LOCATION (City, town, or county) (State): BALTIMORE MD.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: FR. CVACH & SON, 900 N. CHESTER ST. 5

24a. REC'D BY REGISTRAR — DATE: MAR 17 '59

24b. REGISTRAR'S SIGNATURE: Clifford L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02631

2659

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena R.F.D.
c. LENGTH OF STAY IN 1b: —
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Disney Ave - Clearview Village

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena R.D.
d. STREET ADDRESS: Disney Ave - Clearview Village
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Joseph — Middle: J. — Last: Illich

4. DATE OF DEATH: Month: March — Day: 15 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 11, 1904
9. AGE (In years last birthday): 55 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lieutenant (Ret.)
10b. KIND OF BUSINESS OR INDUSTRY: B. C. Police Dept.
11. BIRTHPLACE (State or foreign country): Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Joseph Illich
14 MOTHER'S MAIDEN NAME: Laura Johnson

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16 SOCIAL SECURITY NO: 218-07-6618
17 INFORMANT: Mrs - Angelina Illich — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 minutes
DUE TO
(b): Coronary insufficiency — several weeks
DUE TO
(c): Diabetes mellitus — 7 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): defective vision
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour — a. m. p. m. — Month — Day — Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March 1, 1954 to March 15, 1959 that I last saw the deceased alive on March 14, 1959, and that death occurred at 2 a. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. — ADDRESS (Street, city or town, state): R.F.D. Box 442 Pasadena, Md. — DATE SIGNED: March 15 1959

PHYSICIAN'S NAME (Type): R. M. McLaughlin M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 18, 1959
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven
22d LOCATION (City, town, or county) (State): Glen Burnie Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: SINGLETON FUNERAL HOME, GLEN BURNIE, MD.
24a REC'D BY REGISTRAR DATE: MAR 18 '59
24b REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director. page 3 should be detached for use as the burial-transit permit. Then please re[illegible] carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02632

2660 Item 9 Film G240 4-1-59 et

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gambrills
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mineral
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: MILDRED — Middle: ANN — Last: JACKSON

4. DATE OF DEATH: Found — Month: March — Day: 21 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/12/31

9. AGE (In years last birthday): 28 27 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: B. Lewis Hill

14. MOTHER'S MAIDEN NAME: Clara Mallory

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Aspiration of Blood due to Multiple

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Contusions of Face and Head due to Multiple Blunt Impacts to the Head, and Ligature

(c) Encirclement of Neck.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Assaulted by unidentified assailant.

20c. TIME OF INJURY: Hour ~~XX~~ p m — Month, Day, Year: 1/11 1959

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.): Unknown

20f. (City or town) Unknown (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Russell S Fisher M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 3/24/59

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar. 26, 1959

22c. NAME OF CEMETERY OR CREMATORY: Jackson Family Cemetery,

22d. LOCATION (City, town, or county): Pendleton, (State) Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Woodward Funeral Home Lavinia Va

24a. REC'D BY REGISTRAR DATE: MAR 30 '59

24b. REGISTRAR'S SIGNATURE: Clifton B Howard

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delays necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02633

Reg. Dist. No. 2661

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM1. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in no event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Gambrills
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mineral
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First SUSAN — Middle ANNE — Last JACKSON

4. DATE OF DEATH: Found — Month March — Day 21 — Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/1/54

9. AGE (In years last birthday): 5 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Carroll Vernon Jackson, Jr.

14. MOTHER'S MAIDEN NAME: Mildred Ann Hill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Craniocerebral Injury with Fracture of Skull,

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Left Subdural Hematoma and Left Frontal Contusions with Aspiration of Blood due to Multiple Blunt
(c): Impacts to the Head.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18): Assaulted by unidentified assailant.

20c. TIME OF INJURY: Hour 2000 p. m. — Month, Day, Year 1/11 1959

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Unknown

20f. (City or town) Unknown (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Russell S. Fisher M.D.

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 3/24/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Mar. 26, 1959

22c. NAME OF CEMETERY OR CREMATORY: Jackson Family Cemetery

22d. LOCATION (City, town, or county) (State): Pendleton, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Woodward Funeral Home, Lavina Va.

24a. REC'D BY REGISTRAR DATE: MAR 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2662 **CERTIFICATE OF DEATH** Reg. Dist. No. 02634

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 9yr.6mo 17days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sparks, MARYLAND
d. STREET ADDRESS: ?
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: — Last: Jackson
4. DATE OF DEATH: Month: 3 — Day: 9 — Year: 19 59
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 5/18/95
9. AGE (In years last birthday): 63 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming
10b. KIND OF BUSINESS OR INDUSTRY: ---------
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Victory Jackson
14. MOTHER'S MAIDEN NAME: Susan Venex
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Dehydration, Inanition and Toxemia — INTERVAL BETWEEN ONSET AND DEATH
332 ×
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Decubitus Ulcers
DUE TO
(c): Cerebral Thrombosis with Right-Handed Hemiplegia-Old

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 334 × Hypertensive Cardiovascular Disease CNS Sypnilis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 ---------
20d. INJURY OCCURRED While at work ☐ Not while at work ☐ ----------
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----------
20f. (City or town) (County) (State) ----------

21. I certify that I attended the deceased from 8/22, 1949, to 3/9, 1959, that I last saw the deceased alive on 3/9, 19 59, and that death occurred at 10:30P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 3/10/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D. — Crownsville State Hospital, Md. — 3/10/59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3-12-59
22c. NAME OF CEMETERY OR CREMATORY: STEAVENSON A.M.E.
22d. LOCATION (City, town, or county) (State): SPARKS, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: William a Jackson Inc
ADDRESS: 914 PENNA. AVE.

24a. REC'D BY REGISTRAR: DATE MAR 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

02635

CERTIFICATE OF DEATH

2663 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena (Rural)
c. LENGTH OF STAY IN 1b: 15 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Mountain Road, RFD 3, Box 6

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
d STREET ADDRESS: Mountain Road, RFD 3, Box 6
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ahrie Middle: G. Last: Jenkins
4. DATE OF DEATH: Month: March Day: 13 Year: 1959

5 SEX: Female
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 12, 1875
9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11 BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Daniel L. Stone
14 MOTHER'S MAIDEN NAME: . Elizabeth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: -------
17 INFORMANT Address: Mrs Elizabeth Hahn, same as 2

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arterio- Sclerotic Cardio-Vascular Desease — INTERVAL BETWEEN ONSET AND DEATH

4 2 2.1

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p m Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1951, to 3/13/59, 19, that I lost saw the deceased alive on 3/17/59, 19, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Gustave H Faubert M.D — ADDRESS (Street, city or town, state): — DATE SIGNED: 3/14/59

PHYSICIAN'S NAME (Type): Gustave H. Faubert, M.D. — 5 First Ave. SE, Glen Burnie, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/17/59
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d LOCATION (City, town, or county) (State): Baltimore 24, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hopping and Kirkley, Glen Burnie, Md.
24a REC'D BY REGISTRAR DATE: MAR 17 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2664 — Reg. Dist. No. 02636

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hanover
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Ridge Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Hanover
d. STREET ADDRESS: Ridge Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Annie; Middle: Frances; Last: Johnson

4. DATE OF DEATH: Month: March; Day: 16; Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 17, 1893

9. AGE (In years last birthday): 66 yrs

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): never worked

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William George Johnson

14. MOTHER'S MAIDEN NAME: Annie Maria Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Edward N. Jones, Ridge Road, Hanover, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): DIABETIC COMA

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): DIABETESE MELLITUS

DUE TO

(c): GENERALIZED ARTERIOSCLEROSIS

INTERVAL BETWEEN ONSET AND DEATH: 6 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): MYOCARDIAL DISEASE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: ; a. m. ☐ p. m. ☐ Month: ; Day: ; Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1956 to 3 March, 1959 that I last saw the deceased alive on 3 March, 1959, and that death occurred at 2A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: George E Gerlach M.D. — ADDRESS (Street, city or town, state): 5608 Main St Glenridge Z Md — DATE SIGNED: 16 March 59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3-18-59

22c. NAME OF CEMETERY OR CREMATORY: Elkridge Methodist Ceme

22d. LOCATION (City, town, or county) (State): Elkridge, Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: William Cook, Inc., 1217 St. Paul Street

24a. REC'D BY REGISTRAR DATE: MAR 18 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2665

CERTIFICATE OF DEATH

02637

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 6yr.10mo.4days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Reisterstown
d. STREET ADDRESS: ?
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Katie — Middle: — Last: Jordan

4. DATE OF DEATH: Month: 3 — Day: 23 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 10,1890

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert Moore

14. MOTHER'S MAIDEN NAME: Kitty Shorter

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): AHCVD
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. ------- 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ----------

20f. (City or town) (County) (State): -------

21. I certify that I attended the deceased from 5/19, 1952, to 3/23, 1959, that I last saw the deceased alive on 3/23, 1959, and that death occurred at ---- M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Hildegard Heard Reissman M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 3/23/59

PHYSICIAN'S NAME (Type): Hildegard Heard Reissman, M. D. — Crownsville State Hospital, Md. — 3/23/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 26 Mar. 1959

22c. NAME OF CEMETERY OR CREMATORY: St. Luke's-

22d. LOCATION (City, town, or county) (State): Reisterstown Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. F. Eline & Sons- Reisterstown, Md.

24a. REC'D BY REGISTRAR DATE: MAR 26 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 and the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2617 CERTIFICATE OF DEATH

Reg. Dist. No. 11263

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 20 Jefferson Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Irene — Middle: Lorraine — Last: Katris

4. DATE OF DEATH: Month: March — Day: 27 — Year: 19 59

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 27, 1959

9. AGE (In years last birthday) yrs

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS: Hours: 4 | Min.: 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ———

10b. KIND OF BUSINESS OR INDUSTRY: ———

11. BIRTHPLACE (State or foreign country): Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William John Katris

14. MOTHER'S MAIDEN NAME: Margaret W. Dennison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): ———
(If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.: ———

INFORMANT: Mother — Address: 20 Jefferson Place, Annapolis, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): asphyxia — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs
DUE TO (b): failure to initiate respirations
DUE TO (c): ponte CNS depr (congenital)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that I attended the deceased from 3/26/57, 19 57 to 3/27/57, 19 57, that I last saw the deceased alive on 3/27/57, 19 57, and that death occurred at 12:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Borsuck M.D. — ADDRESS (Street, city or town, state): Annapolis Md — DATE SIGNED: 3/28/57

PHYSICIAN'S NAME (Type): S. Borsuck

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 28, 1959

22c NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery

22d LOCATION (City, town, or county) (State): Annapolis, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Hopkins Funeral Home — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: MAR 31 '59

24b REGISTRAR'S SIGNATURE: Arthur S. Krause

XV 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02639
Reg. Dist. No.

2618

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A A General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sylvan Shores R.F.D.
d. STREET ADDRESS: Annapolis Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thomas Middle E. Last Keen

4. DATE OF DEATH: Month 3 Day 21 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov 11th 1893
9. AGE (Last birthday): 66 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Engineer
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Thomas S. Keen
14. MOTHER'S MAIDEN NAME: Margaret Reese

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Edna S. Keen — Address (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Sudden
434.4
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour ___ a. m. p. m. Month, Day, Year 19___
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): E. Linhardt
DATE SIGNED: 3/21/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-24-59
22c. NAME OF CEMETERY OR CREMATORY: London Park Cemt
22d. LOCATION (City, town, or county): Baltimore (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John W. Taylor Sons ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR: DATE MAR 24 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2619

CERTIFICATE OF DEATH

Reg Dist. No. 02640

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural - Edgewater,
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEDENT (Type or print): First: Frank — Middle: A. — Last: KENNEDY

4. DATE OF DEATH: Month: March — Day: 27 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/14/94

9. AGE (In years last birthday): 64 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): News Corresponden

10b. KIND OF BUSINESS OR INDUSTRY: Newspaper

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Maj. James Stewart Kennedy

14. MOTHER'S MAIDEN NAME: Cora Belle Hiteshew

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 578-46-2892

INFORMANT: Mary Anne Kennedy — Address: Edgewater, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 1 mo

177 X

DUE TO (b): Metastases

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Carcinoma of Prostate — 2 1/2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: — o. m. / p. m. — Month: — Day: — Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/8/56 to 3/26/59, that I last saw the deceased alive on 3/26/59, and that death occurred at 3:10 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edwin Davis, Jr. M.D. — ADDRESS (Street, city or town, state): 98 Cathedral St, Annapolis, Md. — DATE SIGNED: 3/27/59

PHYSICIAN'S NAME (Type): Edwin Davis, Jr.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation — 22b. DATE THEREOF: 3/28/59 — 22c. NAME OF CEMETERY OR CREMATORY: Pet's Crematorium - Wash D C — 22d. LOCATION (City, town, or county) (State):

23. FUNERAL DIRECTOR'S SIGNATURE: Pet Funeral Home - D C — ADDRESS:

24a. REC'D BY REGISTRAR DATE: MAR 30 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be received by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02641

2666

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
c. LENGTH OF STAY IN 1b 1 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sands Nursing Home

2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie
d. STREET ADDRESS —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Irene Middle I Last Kilby

4. DATE OF DEATH Month 3 Day 14 Year 19 59

5. SEX F. 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH August 12-1900 9. AGE (In years last birthday) 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY — 11 BIRTHPLACE (State or foreign country) [redacted] MD. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Wright 14 MOTHER'S MAIDEN NAME Alice Willhide

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) 16 SOCIAL SECURITY NO 17. INFORMANT Walter S. Kilby Address Glen Burnie, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Aspiration Pneumonia
DUE TO (b) Pleurisy
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Multiple Lesions - Liver

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2-12 19 59 to 3-19 19 59, that I last saw the deceased alive on 2-13 19 59, and that death occurred at 5:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Helen Greenberg M.D ADDRESS (Street, city or town, state) 1 E. Read St. Baltimore DATE SIGNED 3-19-59

PHYSICIAN'S NAME (Type) Helen Greenberg

22a BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 3-21-59 22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial 22d. LOCATION (City, town, or county) Glen Burnie (State) Md

23 FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons ADDRESS Annapolis Md 24a. REC'D BY REGISTRAR DATE MAR 23 '59 24b REGISTRAR'S SIGNATURE Arthur E. Krauss

VS A15 (4)
11M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2667

CERTIFICATE OF DEATH

Reg. Dist. No. 02642

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort G. G. Meade, Md
c. LENGTH OF STAY IN 1b: 10 Mo's
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: US Army Hospital, Bldg 2101-1)

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 1815 Maltravers Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry — Middle: L. — Last: Krauss

4. DATE OF DEATH: Month: Mar — Day: 28 — Year: 19 59

5. SEX: M

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 29 Nov 1894

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: ~~Unknown~~ Ignaty Krauss

14. MOTHER'S MAIDEN NAME: ~~Unknown~~ Mary ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 107052213

17. INFORMANT: (Son) Melvin H. Krauss, Address: Glen Burnie, Md. 1815 Maltravers Rd,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Multiple Cerebral Emboli — INTERVAL BETWEEN ONSET AND DEATH: 14 Days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Myocardial Infarction — 18 Days

DUE TO

(c): Arteriosclerotic Heart Disease — 6 Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bleeding Duodenal Ulcer

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February, 1959, to 28 March, 1959, that I last saw the deceased alive on ~~28 March~~, 1959, and that death occurred at 11 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Allan H. Toffler M.D. ADDRESS (Street, city or town, state): U.S. Army Hosp. Ft. Meade, Md. DATE SIGNED

PHYSICIAN'S NAME (Type): Allan H. Toffler, Capt MC

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal

22b. DATE THEREOF: 3/28/59

22c. NAME OF CEMETERY OR CREMATORY: United Hebrew

22d. LOCATION (City, town or county) (State): New York, N Y

23. FUNERAL DIRECTOR'S SIGNATURE: Sol Jennson & Bro — ADDRESS: 1124 W. North Ave

24a. REC'D BY REGISTRAR DATE: MAR 31 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Powell

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2668 — Reg. Dist. No. — 02643

1. PLACE OF DEATH
a. COUNTY: A. A. Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Orchard Beach
c. LENGTH OF STAY IN 1b: 5 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1208 Beach Promanade

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Orchard Beach
d. STREET ADDRESS: 1208 Beach Promanade
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mamie Middle E. Lost Kritwise

4. DATE OF DEATH: Month March Day 31/59 Year 19

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 7, 1890

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H. W.

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ———Schrader

14. MOTHER'S MAIDEN NAME: Elizabeth———

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Geo. F. Kritwise, Orchard Beach, A.A. Co. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
4.20.1
DUE TO (b): Arteriosclerotic Cardio-vascular Disease — 2 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 20, 1955 to March 31, 1959 that I last saw the deceased alive on March 29, 1959 and that death occurred at 6:45 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Randall M. McLaughlin M.D. — ADDRESS (Street, city or town, state): R.F.D. X Box 442 Pasadena, Md. — DATE SIGNED: Mar. 31, 1959

PHYSICIAN'S NAME (Type): Randall M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 3/59

22c. NAME OF CEMETERY OR CREMATORY: Loudon Park

22d. LOCATION (City, town, or county) (State): Baltimore 29, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Witzke Funeral Directors, 4101 Edmondson Ave.

24a. REC'D BY REGISTRAR: DATE APR 1 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kramer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 8/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2620 **CERTIFICATE OF DEATH** 02644

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY A. A. Co MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY A. A. Co

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAND BEACH

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First JOSEPH Middle ISRAEL Last LASALLE

4. DATE OF DEATH Month 3 Day 15 Year 1959.

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH 3/27/78

9. AGE (In years last birthday) 81 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Health Inspector

10b. KIND OF BUSINESS OR INDUSTRY District of Columbia

11. BIRTHPLACE (State or foreign country) Carthage N.Y

12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Baptiste La Salle

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service) —

16 SOCIAL SECURITY NO 579-36-3933

INFORMANT Widow Michaelis Address Rt 3, Box 218, Edgewater, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 2 hrs

420.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/14, 1959, to 3/15, 1959, that I last saw the deceased alive on 3/14, 1959, and that death occurred at 12:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Richard W Peeler M.D. ADDRESS (Street, city or town, state) 121 CATHEDRAL ST DATE SIGNED 3/17/59

PHYSICIAN'S NAME (Type) RICHARD W PEELER ANNAPOLIS, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b DATE THEREOF 3/18/59

22c. NAME OF CEMETERY OR CREMATORY Ft LINCOLN

22d LOCATION (City, town, or county) (State) Bladensburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardesty ADDRESS Galesville Md

24a. REC'D BY REGISTRAR DATE MAR 23 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

FOR STATE HEALTH DEPT.

M

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
8M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2669

02645

Reg. Dist. No.

1 PLACE OF DEATH
a COUNTY: Anne Arundel — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Dan's Mountain Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE: Md.
b COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
d STREET ADDRESS: R.F.D.
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Alma — Middle: E. — Last: Lewis
4. DATE OF DEATH: Month: Mar. — Day: 16, — Year: 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov 5 1876
9. AGE (In years last birthday): 82 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Miss.
12 CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Hamilton Bilb.
14 MOTHER'S MAIDEN NAME: Frances Hines
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: Unknown
17. INFORMANT: Mrs B.M. Gaddis
Address: 1115 N Washington Blvd Arl. Va.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — Interval between onset and death: Sudden
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture Hip
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☑ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Fell & fracture hip.
20c. TIME OF INJURY: Hour, a. m., p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home
20f. (City or town): Alco (County) (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E Lankford
EXAMINER'S NAME (Type): E. Lankford, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3/16/57.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar 18, 1957
22c. NAME OF CEMETERY OR CREMATORY: N. H. Cem
22d LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: H W Lamb & Co Inc
ADDRESS: 14th & Chapin Sts N.W. Wash D.C.
24a. REC'D BY REGISTRAR: DATE MAR 20 '59
24b REGISTRAR'S SIGNATURE: Arthur L. Howard

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2670 **CERTIFICATE OF DEATH** 02646

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PASADENA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RTE. 1, BOX 305, FOREST GLEN

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: ANNE ARUNDEL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PASADENA
d. STREET ADDRESS: RTE. 1, BOX 305, FOREST GLEN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First RUDOLPH — Middle E. — Last MACK
4. DATE OF DEATH: Month MAR. — Day 26 — Year 1959
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: NOV. 21, 1895
9. AGE (In years last birthday): 63 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK
10b. KIND OF BUSINESS OR INDUSTRY: DAVISON CHEM.
11. BIRTHPLACE (State or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: GEORGE H. MACK
14. MOTHER'S MAIDEN NAME: AUGUSTA WITTE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: LILLIAN K. MACK — Address: PASADENA, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Carcinomatosis	5 months
DUE TO (b)	Carcinoma of the Lungs	5 months
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from October 23, 1958 to March 26 1959 that I last saw the deceased alive on March 24, 1959, and that death occurred at 4:05 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R. M. McLaughlin M.D. — ADDRESS (Street, city or town, state): RED & Box 442 Pasadena, Md. — DATE SIGNED: March 26 1959

PHYSICIAN'S NAME (Type): R. M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3-30-59
22c. NAME OF CEMETERY OR CREMATORY: OAK LAWN
22d. LOCATION (City, town, or county) (State): BALTO. CO. MD.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: C. F. Hoffmann 3218 HUDSON ST.
24a. REC'D BY REGISTRAR DATE: MAR 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur J. Krome

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG259 3-4-,) et

2671

CERTIFICATE OF DEATH

02647

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dal-sey
c. LENGTH OF STAY IN 1b: 3 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Race Road

2. USUAL RESIDENCE (Where deceased lived. If institution, last residence before admission)
a. STATE: Md
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Dorsey
d. STREET ADDRESS: 1 Race Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel — Middle: J — Last: Magee

4. DATE OF DEATH: March 1 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 19, 1871

9. AGE (In years last birthday): 87[illegible] yrs.
IF UNDER 1 YEAR: Months 11 Days — IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ? Unk.

14. MOTHER'S MAIDEN NAME: Unk.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Irene Keenan — Address: Race Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

4 DUE TO
(b): Arteriosclerotic Cardiovascular Disease —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c): Generalized Arteriosclerosis —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2-13, 1959 to 3-1, 1959 that I last saw the deceased alive on 3-1-59, 19[illegible], and that death occurred at 12[illegible] P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Jose M. Yosuico M.D. — ADDRESS (Street, city or town, state): RFD #1 Jessup — DATE SIGNED: 3-1-59

PHYSICIAN'S NAME (Type): Jose M. Yosuico, M.D. — RFD # 1, Jessup, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/4/59
22c. NAME OF CEMETERY OR CREMATORY: St. Francis Cemetery
22d. LOCATION (City, town, or county) (State): Pawtucket, R. I.

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible] Kirkley — ADDRESS: Hopping and Kirkley, Glen Burnie, Md.

24a. REC'D BY REGISTRAR DATE: MAR 4 59

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02649

2673 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY AA MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn
c. LENGTH OF STAY IN 1b Yrs.
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Church St.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY AA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn
d STREET ADDRESS 106 Church St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First George (Gaetano Barboni) Middle Last Martin
4. DATE OF DEATH Month 3/ Day 14/ Year 19 59

5 SEX M
6. COLOR OR RACE W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2-1-1890
9 AGE (In years last birthday) 69 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef
10b. KIND OF BUSINESS OR INDUSTRY Hotel Business
11 BIRTHPLACE (State or foreign country) Switzerland
12 CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME Unknown
14 MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 1
16. SOCIAL SECURITY NO 578 09 2853
17. INFORMANT Family Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Carcinomatosis & Metastasis
163X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH: Nov-58 to March 59

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Nov, 1958, to 14 March, 1959, that I last saw the deceased alive on 14 March, 1959, and that death occurred at 9:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Andrew R Sosnowski M.D. ADDRESS (Street, city or town, state) 4016 Ritchie Hwy DATE SIGNED 14 March 59
PHYSICIAN'S NAME (Type) Andrew R. Sosnowski Balto-25-Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3/19/59
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.
22d LOCATION (City, town, or county) (State) Brooklyn, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McCully Funeral Homes 130 E. Fort Ave.
24a. REC'D BY REGISTRAR DATE MAR 17 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Howe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
BM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02650

Reg. Dist. No. 2674

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 2 Box 96, Sansers Park

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same — b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Marlene — Middle Elizabeth — Last McAvoy
4. DATE OF DEATH: Month March — Day 5th — Year 1959
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9/27/58
9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months 5 — Days 6
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): St. Agnes Hosp. Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert McAvoy
14. MOTHER'S MAIDEN NAME: Barbara Holthouse

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Mr and Mrs. Robert McAvoy (parents)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute pulmonary infection. — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Malnutrition — Since birth.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY — Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H Faubert M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED 3/5/59

EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/7/59
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Baltimore 25, Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: James L Kirkley — Hopping and Kirkley, Glen Burnie, Md.
24a. REC'D BY REGISTRAR: DATE MAR 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

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1

FOR STATE HEALTH DEPT.

Item 2: Med. Exam.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03887

2675 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis Junction
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Middle Patuxent River nr. B&O RR Bridge

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Virginia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Richmond
d. STREET ADDRESS: 512 Light Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: NATHANIEL — Middle: — Last: McCOY

4. DATE OF DEATH: Month: March — Day: 15 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: approx.

9. AGE (In years last birthday): 43 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?

I

13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral contusions — INTERVAL BETWEEN ONSET AND DEATH:

902.8

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(b) Fractured skull
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Fall from bridge
20c. TIME OF INJURY: Hour: UNKNOWN — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Bridge
20f. (City or town) Annapolis Junction (County) Anne Ar. (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty M D — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☒ — DEPUTY MEDICAL EXAMINER ☐ — DATE SIGNED: March 16/59

EXAMINER'S NAME (Type): Charles S. Petty, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): 22b. DATE THEREOF: 4.27.59 — 22c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med School — 22d. LOCATION (City, town, or county): Baltimore, Md (State)

23. FUNERAL DIRECTOR'S SIGNATURE: — ADDRESS:

24a. REC'D BY REGISTRAR DATE: APR 28 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

2

3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14, Film 0240, 3/[illegible] Ky

2676

CERTIFICATE OF DEATH

02651

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MAGO VISTA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: RIVER ROAD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD — b. COUNTY: ST. MARYS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LEONARDTOWN
d. STREET ADDRESS: NUNS OAK
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: ADA — Middle: M. — Last: McCULLOUGH

4. DATE OF DEATH: Month: MARCH — Day: 13 — Year: 19 59

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 3, 1875

9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (State or foreign country): ENGLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: —— FARMER

14. MOTHER'S MAIDEN NAME: Not known

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: David McCullough — Address: Mago Vista, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 mo.

443 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive cardio-vascular disease

DUE TO (c): Pneumonia, bronchial

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 19 57, to Mar. 13, 1959, that I last saw the deceased alive on March 10, 19 59, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Francis I. Codd M.D. — ADDRESS (Street, city or town, state): P.O.Box 289 Severna Park, Md. — DATE SIGNED: 3-13-59

PHYSICIAN'S NAME (Type): FRANCIS I. CODD M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 3-16-59 — 22c. NAME OF CEMETERY OR CREMATORY: Cathedral — 22d. LOCATION (City, town, or county) (State): Lusby Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Farlow Funeral Home — ADDRESS: Calvert, Md.

24a. REC'D BY REGISTRAR DATE: MAR 19 '59

24b. REGISTRAR'S SIGNATURE: Clifton L. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02652

Reg. Dist. No.

2677

1. PLACE OF DEATH
a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BAY RIDGE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 52 RIVER DRIVE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: A. A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X BAY RIDGE
d. STREET ADDRESS: 52 RIVER DRIVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DANIEL — Middle E. — Last McELLIN

4. DATE OF DEATH: Month 3 — Day 4 — Year 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-11-1879

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONTRACTOR RET.

10b. KIND OF BUSINESS OR INDUSTRY: PLASTER

11. BIRTHPLACE (State or foreign country): IRELAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: "UNK"

14. MOTHER'S MAIDEN NAME: ~~VICTORIA~~ "UNK"

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: VICTORIA McELLIN — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia due to coal gas
890.0
DUE TO (b): (furnace)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Fell and [illegible] in room - defective furnace caused coal fumes.

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year: Mar 4 1959

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): In home

20f. (City or town) (County) (State): Arnold's Anne Arundel Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: S. Borsuk M.D.
EXAMINER'S NAME (Type): S BORSUK

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3/5/59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 3-6-59
22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet
22d. LOCATION (City, town, or county) (State): Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: MAR 9 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02653

2678 CERTIFICATE OF DEATH

Item 1 FilmG241 4-6-59 et

Reg. Dist. No. .....

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH

COUNTY A A Co Md — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Arnold — LENGTH OF STAY (in this place) Life

HOSPITAL OR INSTITUTION OR STREET ADDRESS At home

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md — COUNTY A A Co

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold A A Co Md

STREET ADDRESS (If rural, give location) Box 498 Rt 2

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John	J	McLaughlin	March	31	1959

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE Last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Sept. 5, 1886	72 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Packer		Md	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James McLaughlin	Mary Solmundth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S ADDRESS
no		216-10-2654	Viola M McLaughlin

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

507.1 IMMEDIATE CAUSE (A) VIRUS PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH 24 HRS.

ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) PNEUMONIA CONGESTIVE

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-7, 19 59, to 3-27, 19 59, that I last saw the deceased alive on 3-27, 19 59, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

SIGNATURE	ADDRESS (Street, city, town, state)	DATE SIGNED
Fred C. Ferry M.D.	201 B+A Blvd, Glen Burnie, Md	3-28-59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	March 31-59	Glen Haven	Glen Burnie A A Co Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
MAR 31 '59	Arthur S. Krauss	Leonard A Funk Glen Burnie Md

1 3

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02654

Reg. Dist. No. 2679

1. PLACE OF DEATH a. COUNTY: A.A Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOH Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE: MD — b. COUNTY: AA Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena
d. STREET ADDRESS: Jacobsville Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: M — Last: McWilliams
4. DATE OF DEATH: Month: 3 — Day: 4 — Year: 19 59

5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 14 1884
9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Carberry
14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: James McWilliams — Address: Jacobsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac — INTERVAL BETWEEN ONSET AND DEATH: Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): — DUE TO (c): 434.4

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linhardt
EXAMINER'S NAME (Type): E. Linhardt
M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-4-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-9-59
22c. NAME OF CEMETERY OR CREMATORY: St Peters
22d. LOCATION (City, town, or county) (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Leo D. Nelson — ADDRESS: 1348 N. Calhoun St
24a. REC'D BY REGISTRAR DATE: MAR 6 '59
24b. REGISTRAR'S SIGNATURE: Arthur J. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
BM 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2680 — Reg. Dist. No. 02655

1 PLACE OF DEATH
a. COUNTY: A.A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6 Meadow Rd.

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Glen Burnie~~ Pasadena
d. STREET ADDRESS: 6 Meadow Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Catherine — Middle: A. — Last: Meyers

4. DATE OF DEATH: Month: 3 — Day: 26 — Year: 59

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☑ **NEVER MARRIED** ☑ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 1-2-20

9. AGE (In years last birthday): 39 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cash. Mgr.

10b. KIND OF BUSINESS OR INDUSTRY: Pasadena Sel.

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Michael Wengert

14. MOTHER'S MAIDEN NAME: Eliz. Higdon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Family — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 1 years
DUE TO (b): Carcinoma of the cervix — 1 year
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 171X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m., 19

20d. INJURY OCCURRED White at work ☐ Not white at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from September 9, 19 58, to March 26, 19 59, that I last saw the deceased alive on March 24, 19 59, and that death occurred at 9:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R.M. McLaughlin M.D — ADDRESS (Street, city or town, state): RFD 8 Box 442 Pasadena Md. — DATE SIGNED: March 26, 59

PHYSICIAN'S NAME (Type): R.M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): B. — **22b. DATE THEREOF**: 3/30/59 — **22c. NAME OF CEMETERY OR CREMATORY**: Glen Haven — **22d. LOCATION** (City, town, or county) (State): Balto.

23. FUNERAL DIRECTOR'S SIGNATURE: McCleary Funeral Home — **ADDRESS**: 130 E. Fort Ave.

24a. RECD. BY REGISTRAR DATE: MAR 30 59 — **24b. REGISTRAR'S SIGNATURE**: Clinton S. Trone

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02656

2681

CERTIFICATE OF DEATH

Reg. Dist. No. 27

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ft George G Meade

c. LENGTH OF STAY IN 1b:

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S.Army Hospital

d STREET ADDRESS: 417 W. Pratt St

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JOSEPH Middle P Last MILENSKAS

4. DATE OF DEATH: Month March Day 11 Year 1959

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 15 Oct 1889

9. AGE (In years last birthday): 69 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: -

11 BIRTHPLACE (State or foreign country): Russia (Maryample Lithuania USA

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: ~~Unknown~~ Joseph Milenskas

14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WW 1 & WW II

16 SOCIAL SECURITY NO: None

17 INFORMANT: Mrs Adele Last 84 High St Sharon Hill, Pa — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 10 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 241X

DUE TO (b): COR Pulmonale — Chronic

DUE TO (c): Asthma

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 11 March, 1959, to 11 March, 1959, that I last saw the deceased alive on 11 March, 1959, and that death occurred at 0500 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Fred W. Lafferty M.D. — ADDRESS (Street, city or town, state): U.S.Army Hospital, Ft Meade, Md — DATE SIGNED: 11 Mar 59

PHYSICIAN'S NAME (Type): FRED W. LAFFERTY, Capt, MC — U.S.Army Hospital, Ft George G. Meade, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

22b. DATE THEREOF: 3-12-59

22c. NAME OF CEMETERY OR CREMATORY: Arlington Cemetery

22d. LOCATION (City, town, or county) (State): Drexel Hill, Pennsylvania

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: William Cook, Inc., 1217 St. Paul Street

24a. REC'D BY REGISTRAR DATE: MAR 13 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2682

CERTIFICATE OF DEATH

02657

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Epping Forest
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Epping Forest
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Maude Middle P. Last Miller

4. DATE OF DEATH: Month March Day 17 Year 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-11-1890

9. AGE (In years last birthday): 68 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK PENN R.R.Co.

10b. KIND OF BUSINESS OR INDUSTRY: CLERK

11. BIRTHPLACE (State or foreign country): PENNA.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: EDGAR L. MILLER

14. MOTHER'S MAIDEN NAME: CORA WASHINGER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. R. G. Watts — Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 15 MINUTES

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): HYPERTENSIVE CARDIOVASCULAR DISEASE — 8 YEARS

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/11, 1959 to 3/17, 1959, that I last saw the deceased alive on 3/17, 1959, and that death occurred at 6:50 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE OF PHYSICIAN'S NAME (Type): Edward L Bost M.D.

ADDRESS (Street, city or town, state): 41 Southgate Ave Annapolis, Md

DATE SIGNED: 3/17/59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 3-20-59

22c. NAME OF CEMETERY OR CREMATORY: VORLAND CEMETERY

22d. LOCATION (City, town, or county): CHAMBERSBURG (State) PA.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor & Sons

ADDRESS: Annapolis, Md.

24b. REC'D BY REGISTRAR DATE MAR 20 '59

24b. REGISTRAR'S SIGNATURE: Antonia S. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2621 **CERTIFICATE OF DEATH** Reg. Dist. No. 02658

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospt.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 1308 McKinley St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Bertha — Middle: Mae — Last: Myers

4. DATE OF DEATH: Month: 3 — Day: 6 — Year: 1959

5. SEX: F
6. COLOR OR RACE: W
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-13-1882
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: Home.
11. BIRTHPLACE (State or foreign country): Penna.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Myers
14 MOTHER'S MAIDEN NAME: Elizabeth Bollinger

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Gretchen Satchell — Address: Warren Rd. Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): arteriosclerotic cardio-vascular — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.
DUE TO (b): heart disease c hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): diabetes mellitus, fractured lt. hip
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): fell at home 12/21/58
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year: 12/21/58
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): home
20f. (City or town) Annapolis, (County) AA (State) Md.

21. I certify that I attended the deceased from June, 1954, to March 7, 1959 that I last saw the deceased alive on March 6, 1959, and that death occurred at 11:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: S. Borssuck M.D. — ADDRESS (Street, city or town, state): Amos Garrett Blvd., — DATE SIGNED: 3/7/59

PHYSICIAN'S NAME (Type): S. Borssuck, M.D. — Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-9-1959
22c. NAME OF CEMETERY OR CREMATORY: Dunstown Cemetery
22d LOCATION (City, town, or county): Lock Haven (State) PA.

23. FUNERAL DIRECTOR'S SIGNATURE: John H. Taylor & Sons — ADDRESS: Annapolis Md.
24a. REC'D BY REGISTRAR DATE: MAR 11 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2622

CERTIFICATE OF DEATH

02659

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 1227 Tyler Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: RICHARD — Middle: ALLEN — Last: NICHOLS

4. DATE OF DEATH: Month: March — Day: 9 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 14, 1897

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Linesman (Ret)

10b. KIND OF BUSINESS OR INDUSTRY: Gas & Electric

11. BIRTHPLACE (State or foreign country): Anne Arundel County, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Luther M Nichols

14. MOTHER'S MAIDEN NAME: Louise Anderson ~~Sherrill~~

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown. If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 212-05-5961

17. INFORMANT: John Walter Nichols — Address: Defense Highway, Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma
DUE TO:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO:
(c):

INTERVAL BETWEEN ONSET AND DEATH: 1 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/18, 1959, to 3/9, 1959, that I last saw the deceased alive on 3/9, 1959, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard N Peeler M.D. — ADDRESS (Street, city or town, state): RICHARD N. PEELER — DATE SIGNED: 3/12/59

PHYSICIAN'S NAME (Type): R.CHARD N PEELER, M.D. — 121 Cathedral St, Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 13, 1959

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial

22d. LOCATION (City, town, or county) (State): Annapolis, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOPPING FUNERAL HOME — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR: DATE MAR 16 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2683 **CERTIFICATE OF DEATH**

Reg. Dist. No. 02669

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dorsey
c. LENGTH OF STAY IN 1b: 10 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Box 272 - Ohio Ave.

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dorsey (Hanover P.O.)
d. STREET ADDRESS: Box 272 - Ohio Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANK Middle EDWARD Last OFFUTT, SR.

4. DATE OF DEATH: Month March Day 9 Year 1959

5 SEX: Male
6 COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 3, 1899
9 AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: U.S.Coast Guard
11 BIRTHPLACE (State or foreign country): Baltimore, Md.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Offutt
14. MOTHER'S MAIDEN NAME: Agnes M. Stallings

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16 SOCIAL SECURITY NO: 218-12-6988
17. INFORMANT Address: Mrs. Alois J. Offutt, Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Tongue — INTERVAL BETWEEN ONSET AND DEATH: 2 1/2 yrs
DUE TO (b): Metastasis to Throat — 4 mos
DUE TO (c): Chr Myocarditis — 2 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year / Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 11, 1956, to March 9, 1959, that I last saw the deceased alive on March 8, 1959, and that death occurred at 4:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. H. Brumbaugh M.D. — ADDRESS (Street, city or town, state): 1609 Main St. — DATE SIGNED: 3/11/59

PHYSICIAN'S NAME (Type): J. H. Brumbaugh — Glen Burnie, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Mar. 13/59
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven
22d. LOCATION (City, town, or county) (State): Glen Burnie, Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: R. V. Singleton — ADDRESS: Glen Burnie, Md.
24a REC'D BY REGISTRAR DATE: MAR 12 '59
24b REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2623

CERTIFICATE OF DEATH

02661

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 26 Calver St.

2. USUAL RESIDENCE (Where deceased lived? If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: A.A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 10 Annapolis
d. STREET ADDRESS: 26 Calver St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lisa Middle: Lynn Last: Parker

4. DATE OF DEATH: Month: 3 Day: 22 Year: 1959

5. SEX: Male
6. COLOR OR RACE: Col.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-12-1956
9. AGE (In years last birthday): 3 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Parker
14. MOTHER'S MAIDEN NAME: Thelma Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
INFORMANT: Thelma Parker
Address: Anna. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anaphylactic Response to parenteral
DUE TO: administration of antibiotic
245X
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: about 2½ hrs

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-22-59, 19__, to 3-22-59, 19__, that I last saw the deceased alive on 1-26-59, 19__, and that death occurred at 10:54 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Aris T. Allen M.D.
ADDRESS (Street, city or town, state): 62 Co Charles (St), Annapolis, Md
DATE SIGNED: 3-23-59

PHYSICIAN'S NAME (Type): ARIS T. ALLEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-25-59
22c. NAME OF CEMETERY OR CREMATORY: Fowlers
22d. LOCATION (City, town or county) (State): Best Gate, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese, D
ADDRESS: Anna. Md.

24a. REC'D BY REGISTRAR DATE: MAR 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2624 — Reg. Dist. No. 02662

1. PLACE OF DEATH — a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSP. OR INSTITUTION: 200 Severn Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Md. — b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 200 Severn Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: E. — Last: Parks
4. DATE OF DEATH: Month: 3 — Day: 19 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 29-1875
9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Watchman
10b. KIND OF BUSINESS OR INDUSTRY: Watchman Ships Yard
11. BIRTHPLACE (State or foreign country): A A Co Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: William S. Parks
14. MOTHER'S MAIDEN NAME: Mary E. Ridgeway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs Leona Swink (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Heart disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

4344

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour: o. m. / p. m. Month: Day: Year: 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-19-59, 19__, to 3/19, 1959, that I last saw the deceased alive on 3/17/59, 19__, and that death occurred 12:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E Linhardt M.D. — ADDRESS (Street, city or town, state): Annapolis, Md. — DATE SIGNED:

PHYSICIAN'S NAME (Type): E. Linhardt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-22-59
22c. NAME OF CEMETERY OR CREMATORY: Cedar Bluff Cem't
22d. LOCATION (City, town, or county): Annapolis (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md.
24a. REC'D BY REGISTRAR DATE: MAR 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Russell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02663

Reg. Dist. No. 2625

1. PLACE OF DEATH
a. COUNTY: A. A. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A. A. General Hospt.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 13 N. Cherry Grove Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Dawson — Last: Perry
4. DATE OF DEATH: Month: 3 — Day: 19 — Year: 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct-31-1902
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S.W.E.S.
10b. KIND OF BUSINESS OR INDUSTRY: Civil Service
11. BIRTHPLACE (State or foreign country): A A Co Md
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John Perry
14. MOTHER'S MAIDEN NAME: Maggie Dawson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Margaret P. White — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ~~Coronary Thrombosis~~.
DUE TO (b): Cardiac Disease — INTERVAL BETWEEN ONSET AND DEATH: sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 434.4
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: [signature] M.D.
EXAMINER'S NAME (Type): E. Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3-19-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-21-59
22c. NAME OF CEMETERY OR CREMATORY: St James Cemetary
22d. LOCATION (City, town, or county): Spacey's (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons
ADDRESS: Annapolis Md.
24a. REC'D BY REGISTRAR DATE: MAR 23 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kuhn

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 [illegible] 3-10-59 ct

02664

CERTIFICATE OF DEATH

2684 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Severn, Md. Private home

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Sev~~ Baltimore
d. STREET ADDRESS: 3403 Woodbine Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thelma Middle Agnes Last Posey
4. DATE OF DEATH: Month 3 Day 3 Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 30, 1902
9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Wm. Lovell
14. MOTHER'S MAIDEN NAME: Sara Hopkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 219-22-1610
17. INFORMANT Address: J. Gardner Posey -3403 Woodbine Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Cancer. — INTERVAL BETWEEN ONSET AND DEATH: 4 Mos
157 ×
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Dec, 19 58 to March, 19 59, that I last saw the deceased alive on March 4, 19 59, and that death occurred at 3 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE OF PHYSICIAN'S NAME (Type): [signature] M.D.
ADDRESS (Street, city or town, state): 204 Crain Hy. Glen Burnie
DATE SIGNED: 3-5-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/9/1959
22c. NAME OF CEMETERY OR CREMATORY: Druid Ridge Cemetery
22d. LOCATION (City, town, or county) (State): Pikesville Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: Ellsworth Armacost-4600 Liberty Hghts. Ave.
24a. REC'D BY REGISTRAR: MAR 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be refiled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02665

2626 Items 10,11,12,13,14 Film G241 4-20-59 et Reg. Dist. No.

1. PLACE OF DEATH a COUNTY A A.Co MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b 1 day
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANNE ARUNDEL GENERAL.

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE MD b COUNTY AA Co
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shadyside
d STREET ADDRESS
e IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Robert Middle Lost Potterfield
4. DATE OF DEATH Month 3 Day 19 Year 1959
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 11-4-83
9. AGE (In years last birthday) 75 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Livestock dealer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Virginia
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Potterfield
14 MOTHER'S MAIDEN NAME Susan Coblenz

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ? (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17 INFORMANT MRS. DORIS WILDE Address Shadyside Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2nd - 3rd. degree Burns
916.0
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH 16 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Burns sustained as result of trunk fire
20c TIME OF INJURY Hour a m. p. m. 3:30 p.m. Month, Day, Year 3-18 1959
20d INJURY OCCURRED While at work ☐ Not while at work ☒
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f (City or town) (County) Anne Arundel (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) E. Linhardt M D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 3-19-59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3/22/59
22c NAME OF CEMETERY OR CREMATORY Lovettsville Va
22d LOCATION (City, town or county) Lovettsville Va (State)

23 FUNERAL DIRECTOR'S SIGNATURE Bernard Hardesty ADDRESS Lovettsville Md
24a REC'D BY REGISTRAR DATE MAR 24 '59
24b REGISTRAR'S SIGNATURE Arthur S. Hawn

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2685 — Reg. Dist. No. 02666

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Queenstown - Severn
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Box 218 Queenstown -Severn

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Box 218~~ Queenstown - Severn
d. STREET ADDRESS: Box # 218
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Albert — Middle: — Last: Queen
4 DATE OF DEATH: Month: March — Day: 29 — Year: 1959

5 SEX: Male
6 COLOR OR RACE: Colored
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: Sept. 24, 1892
9 AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ambrose Queen
14 MOTHER'S MAIDEN NAME: Annie Williams

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17 INFORMANT: Mrs Ethel Queen — Address: Box 218 Queenstown Severn, A.A. Co., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: years
422.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b): Arteriosclerotic Cardio Vascular Disease
DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 13, 1955, to March 29, 1959, that I last saw the deceased alive on Mar. 27, 1959, and that death occurred at 12 A M, from the causes and on the date stated above

ACTUAL SIGNATURE: Bryant L Jones M.D.
PHYSICIAN'S NAME (Type): BRYANT L. JONES, M.D.
ADDRESS (Street, city or town, state): ~~104 Crain Highway, South~~ Glen Burnie, Maryland
Phone: SO 6-3230
DATE SIGNED: 3/30/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4-1-59
22c NAME OF CEMETERY OR CREMATORY: Saints Rest
22d LOCATION (City, town, or county) (State): Harmons, A.A. Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm Flowers & Henry Bowers — ADDRESS: 575
24a. REC'D BY REGISTRAR DATE: APR 1 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] be detached for use as the burial-transit permit. Then please remove carbon paper (Pages 1 page 3 [redacted]) the funeral director, should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

X

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2627 Item 9 Film 239 3-16-59 et

02667

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 917 West St.

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland — b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 917 West St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Claude — Middle — Last Randall

4. DATE OF DEATH: Month 3 — Day 8 — Year 1959

5. SEX: Male

6. COLOR OR RACE: Col.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-30-1874

9. AGE (In years on last birthday): 84 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baggage Man

10b. KIND OF BUSINESS OR INDUSTRY: B. & A. Railroad

11. BIRTHPLACE (State or foreign country): A. A. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Columbus Randall

14. MOTHER'S MAIDEN NAME: Ellen Randall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Helen Randall — Address: Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Burns Generalized — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

416.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY Ooccurred (Enter nature of injury in Part I or Part II of item 18.): Home Fire

20c. TIME OF INJURY: Hour — a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) — (County) — (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Linthicum

EXAMINER'S NAME (Type): E. Linthicum — M D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 3/8/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-11-59

22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

22d. LOCATION (City, town, or county) (State): Annapolis, Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: William Reese, D. — Anna. Md.

24a. REC'D BY REGISTRAR DATE: MAR 10 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02668

Reg. Dist. No. 2623

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 917 West St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
d. STREET ADDRESS 917 West St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Elizabeth Middle Lost Randall

4. DATE OF DEATH Month 3 Day 8 Year 1959

5. SEX Female
6. COLOR OR RACE Col.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3-4-1884
9. AGE (In years last birthday) 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) A.A.Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Whittington
14. MOTHER'S MAIDEN NAME Maria Hebron

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Helen Randall Address Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Burns - generalized — INTERVAL BETWEEN ONSET AND DEATH Sudden
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
916.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Flame Fire
20c. TIME OF INJURY Hour o. m. Month, Day, Year 3-8 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home
20f. (City or town) (County) A.A.Co. (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE [signature] M.D.
EXAMINER'S NAME (Type) E. Linhardt
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 3/11/59

22a. BURIAL CREMATION REMOVAL (Specify) Burial
22b. DATE THEREOF 3-11-59
22c. NAME OF CEMETERY OR CREMATORY Brewer Hill
22d. LOCATION (City, town, or county) Annapolis, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE William Reese, II
ADDRESS Anna. Md.
24a. REC'D BY REGISTRAR DATE MAR 10 '59
24b. REGISTRAR'S SIGNATURE Arthur J. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2686 — Reg. Dist. No. 02669

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FRIENDSHIP
c. LENGTH OF STAY IN 1b: 3 Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BROADWATER, DEALE
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIZABETH Middle JANE Last RANDALL

4. DATE OF DEATH: Month MARCH Day 14 Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 2 1870
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Prince George Co. Md.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Hall
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT: MRS EDA M. King Friendship Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral accident — INTERVAL BETWEEN ONSET AND DEATH
331X
DUE TO
(b): Generalized Arteriosclerosis
DUE TO
(c): hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Not at all 19__, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Emil H. Inlow (acting Coroner) M.D. — ADDRESS (Street, city or town, state): Lothian, Md — DATE SIGNED: 3-17-59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/16/59
22c. NAME OF CEMETERY OR CREMATORY: Woodfield
22d. LOCATION (City, town, or county) (State): Galesville Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Bernard Hardesty — ADDRESS: Galesville Md.

24a. REC'D BY REGISTRAR DATE: MAR 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Reeves

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02670

Reg. Dist. No. 2629

1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) A. A. General Hosp.
e. STREET ADDRESS

2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)
a. STATE Maryland COUNTY A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1706 N. Popular
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First George Middle W Last Randall
4. DATE OF DEATH Month 3 Day 28 Year 1959
5. SEX Male
6. COLOR OR RACE Col.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2-13-1907
9. AGE (In years last birthday) 52 yrs
IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Johnson Lumb. Co
11. BIRTHPLACE (State or foreign country) Harwood, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Randall
14. MOTHER'S MAIDEN NAME Martha Parker
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-05-2496
17. INFORMANT Susie Randall Address Annapolis, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac disease — INTERVAL BETWEEN ONSET AND DEATH Sudden
DUE TO (b) 434.4
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE E. Linhard M.D
EXAMINER'S NAME (Type) E. Linhard
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 3/28/59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 4-2-59
22c. NAME OF CEMETERY OR CREMATORY Brewer Hill
22d. LOCATION (City, town, or county) Annapolis, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE William Reese, II
ADDRESS Anna. Md.
24a. REC'D BY REGISTRAR DATE MAR 31 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Morris

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02671

2687 · **CERTIFICATE OF DEATH**

Reg. Dist. No.

1 PLACE OF DEATH
a COUNTY Anne Arundel C. MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park
c. LENGTH OF STAY IN 1b 27 yrs
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a STATE Md. b. COUNTY A.A
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Severna Park md
d STREET ADDRESS Jumpers Hole Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Agnes Middle Rose Last Regler 1879
4 DATE OF DEATH Month 3 Day 21 Year 59 . 19

5. SEX F
6. COLOR OR RACE W
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 11 Sept 1879
9 AGE (In years last birthday) 79 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b KIND OF BUSINESS OR INDUSTRY Home
11 BIRTHPLACE (State or foreign country) Baltimore Md
12 CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME ? Tasmier
14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17 INFORMANT Address George H. Regler, RFD 1 Box 411 Severna Park

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO (b) Arteriosclerosis C.V. Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1959, 19__, to 1959, 19__, that I last saw the deceased alive on 3-19-59, 19__, and that death occurred at 10:35 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE Robert R. Hahn M.D. ADDRESS (Street, city or town, state) Severna Park DATE SIGNED
PHYSICIAN'S NAME (Type) Robert R. HAHN md 3-21-59

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3/25/59
22c NAME OF CEMETERY OR CREMATORY Most Holy Redeemer
22d LOCATION (City, town, or county) (State) Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE James L Kirkley (ADDRESS) Hopping and Kirkley, Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE MAR 26 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
5M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2688

CERTIFICATE OF DEATH

02672 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 45yr.4mo.23days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: Unknown
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sarah — Middle: — Last: Revells

4. DATE OF DEATH: Month: 3 — Day: 22 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1894

9. AGE (In years last birthday): 64 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: —

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): unknown (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized and Cerebral Arteriosclerosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): ----------

20c TIME OF INJURY Hour a. m. p. m. ----- Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ------

20f (City or town) (County) (State): ----------

21. I certify that I attended the deceased from 10/29, 19 15, to 3/22, 19 59, that I last saw the deceased alive on 3/22 19 59, and that death occurred at 6:32P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 3/23/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D.
Crownsville State Hospital, Md. 3/23/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 3-26-59
22c. NAME OF CEMETERY OR CREMATORY: Anatomy Board of Md.
22d LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John McPeake II
ADDRESS:

24a. REC'D BY REGISTRAR DATE: APR 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9, Film [illegible]

CERTIFICATE OF DEATH

02673

Reg. Dist. No. 2689

1. PLACE OF DEATH
a. COUNTY Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patapsco Park
c. LENGTH OF STAY IN 1b 65
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 219 Bolivar Ave

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland
b. COUNTY H. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 219 Bolivar Ave
d. STREET ADDRESS Patapsco Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First: Monroe Middle: Reynolds Last:
4. DATE OF DEATH Month: 3 Day: 25 Year: 1959

5. SEX: Male
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 3-15-1861
9. AGE (In years last birthday) 98 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Reynolds
14. MOTHER'S MAIDEN NAME Uknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Alice Reynolds - Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b) Senile debility
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. / p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 1959 to March 25, 1959, that I last saw the deceased alive on 3/25/59, 1959, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE [signature] M.D. ADDRESS (Street, city or town, state) 84 Bolivar Elkridge, Md. DATE SIGNED 3/27/59

PHYSICIAN'S NAME (Type) Thos. J. Woolridge

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 3-28-59
22c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem
22d. LOCATION (City, town, or county) (State) Cedar Hill Md.

23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson ADDRESS 2000 Brantley Ave
24a. REC'D BY REGISTRAR DATE APR 6 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02674

2690 Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled ... the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 ... should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 7 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 605 Newfield Road

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
d. STREET ADDRESS: 605 Newfield Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AGNES — Middle P. — Last ROBERTS
4. DATE OF DEATH: Month March — Day 5, — Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 7, 1891
9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleslady
10b. KIND OF BUSINESS OR INDUSTRY: Eagles 5/10 store
11. BIRTHPLACE (State or foreign country): Pittsburgh, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Ferdinand Probst
14. MOTHER'S MAIDEN NAME: Mary Geiser
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): ////////
16. SOCIAL SECURITY NO.: 219-32-5194
17. INFORMANT: Mrs. Wayne Holt — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Respiratory Failure	10 min
DUE TO (b)	Pulmonary Metastases	2 mos
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Primary Hepatic Malignancy	6 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Jaundice

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 6/1/57 to 3/5/59 that I last saw the deceased alive on 3/5/59, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE, M.D.: R. W. Richard — ADDRESS (Street, city or town, state): 715 Cedar Rd Glen Burnie Md — DATE SIGNED: 3/6/59
PHYSICIAN'S NAME (Type): R. W. RICHARD M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 9, 1959
22c. NAME OF CEMETERY OR CREMATORY: Allegheny Co. Mem. Pk.
22d. LOCATION (City, town, or county) (State): Pittsburgh, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Richard VanScoyoc — ADDRESS: Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE: MAR 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 234 3-4-59 et

02675

2630

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annarolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 205 Severn Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KATHERINE — Middle M — Last ROBERTS

4. DATE OF DEATH: Month March — Day 1 — Year 19 59

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 1, 1904

9. AGE (In years last birthday): 77/54 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ho sewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: AUGUSTA HAUCH

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT — Address: CARROLL P R BERTS Husband- Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Ac. Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2yrs
420.1
DUE TO (b): Arteriosclerotic C.V. Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): & hypertension — 15 yrs +

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 25 19 59 to Mar 1 19 59 that I last saw the deceased alive on Mar 1 19 59, and that death occurred at 9 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Maurice F Klawans M.D. — ADDRESS (Street, city or town, state): Annapolis, Md — DATE SIGNED: 3/3/59

PHYSICIAN'S NAME (Type): MAURICE F KLAWANS, MD — 31 Southgate Ave, Annapolis, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 4, 1959

22c. NAME OF CEMETERY OR CREMATORY: Baltimore National

22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: [illegible] FUNERAL HOME, Annapolis, Maryland

24a. REC'D BY REGISTRAR — DATE: MAR 5 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02676

2691

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie
c. LENGTH OF STAY IN 1b: 3 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Forest Box 117 R.F.D. 5 Beechwood

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: A.A. County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Burnie Md.
d. STREET ADDRESS: Forest Box 117 R.F.D. 5 Beechwood
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Le Roy — Middle: E. — Last: Robinson

4. DATE OF DEATH: Month: March — Day: 27 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: July 7, 1874

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired): Police Man

10b. KIND OF BUSINESS OR INDUSTRY: Balto. City

11. BIRTHPLACE (State or foreign country): Maryland Calvert Co.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Robinson

14. MOTHER'S MAIDEN NAME: Margaret V. Bordley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: Mrs. Harry L. Meiser — Address: Box 117 R.F.D. 5 Beechwood Forest

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic Cardiovascular disease
DUE TO
(c): with Cardiac decompensation — 3 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus, 24 years duration

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month — Day — Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 16, 1958 to March 27, 1959, that I last saw the deceased alive on March 25, 1959, and that death occurred at 7:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R.M. McLaughlin M.D — ADDRESS (Street, city or town, state): R.F.D. Box 442 Pasadena Md. — DATE SIGNED: March 27, 1959

PHYSICIAN'S NAME (Type): R.M. McLaughlin

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 30-1959

22c. NAME OF CEMETERY OR CREMATORY: London Park Cem.

22d. LOCATION (City, town, or county) (State): Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE: G. Truman Schwab — ADDRESS: 3512 Frederick Ave (29)

24a. REC'D BY REGISTRAR DATE: MAR 30 59

24b. REGISTRAR'S SIGNATURE: Clifton L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02677

Reg. Dist. No. 2692

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY: Anne Arun del. MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If inst tut on Residence before admission) a. STATE: Md. b. COUNTY: Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
c. LENGTH OF STAY IN 1b: Life
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severna Park
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): D.O.A. Anne Arun del. Gen.
d. STREET ADDRESS: Benfield Rd
e. RESIDENCE ON A FARM: YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First James Middle M. Last Saffield
4. DATE OF DEATH: Month 3 Day 23 Year 1959
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 18, 1881
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard
10b. KIND OF BUSINESS OR INDUSTRY: State of Md.
11. BIRTHPLACE (State or foreign country): A.A.Ct. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Richard Saffield
14. MOTHER'S MAIDEN NAME: Mary Stevens
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 211-26-6741
17. INFORMANT: Lucy Saffield Address: Benfield Rd. Severnar

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

782.4

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: E. Leonard M.D.
EXAMINER'S NAME (Type): E. Leonard
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 3/25/59

22a. BURIAL CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/27/59
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven
22d. LOCATION (City, town, or county) (State): Ritchie Highway Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Schweinsberg Funeral Service 1126 W. Cross St. Balto. 30 Md.
24a. REC'D BY REGISTRAR DATE: MAR 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

W. T. Schweinsberg

VS AISME 5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2631 CERTIFICATE OF DEATH

02678
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A A — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md. b. COUNTY: A A

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A A General Hospt

d. STREET ADDRESS: 309 Gibson Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Ellwood Middle: P. Last: Scherger

4. DATE OF DEATH: Month: 3 Day: 15 Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-27-1898

9. AGE (In years last birthday): 60 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Sheet Metal Worker

10b. KIND OF BUSINESS OR INDUSTRY: Naval Academy

11. BIRTHPLACE (State or foreign country): Annapolis Md

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John K. Scherger

14. MOTHER'S MAIDEN NAME: Maggie Jacobs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): Yes (If yes, give war or dates of service): World War I

16. SOCIAL SECURITY NO.:

17. INFORMANT: Elizabeth C. Scherger — Address: (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m., 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/15, 1959, to 3/15, 1959, that I last saw the deceased alive on 3/15, 1959, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard N Reeler M.D. — ADDRESS (Street, city or town, state): 121 CATHEDRAL ST — DATE SIGNED: 3/12/59

PHYSICIAN'S NAME (Type): RICHARD N. REELER — ANNAPOLIS, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-18-59

22c. NAME OF CEMETERY OR CREMATORY: St Annes Lemt

22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Taylor Sons — ADDRESS: Annapolis Md

24a. REC'D BY REGISTRAR — DATE: MAR 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, 14, Film G251 11-10-59, E.S.

2632

02679

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: A.A. County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): A.A. General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: A.A. Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~[illegible]~~ Odenton
d. STREET ADDRESS: ~~Annapolis~~ Patuxant Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) — First: Franklin — Middle: E. — Last: Sharp

4. DATE OF DEATH — Month: 3 — Day: 30 — Year: 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: ~~Aug. 16 - 1898~~ January 8, 1959

9. AGE (In years last birthday): — yrs — IF UNDER 1 YEAR: Months 2 Days 22 — IF UNDER 24 HRS: Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Annapolis, Marland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank L. Sharp

14. MOTHER'S MAIDEN NAME: Louise B. Russell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: None

INFORMANT — Address: Frank L. Sharp — Patuxant Rd. Odenton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	PERTUSSIS	3 WKS
DUE TO (b)	INTUSSUSSCEPTION SIGMOID, WITH PERFORATION	10 DAYS
DUE TO (c)	OF SIGMOID AND PERITONITIS	2 DAYS

056.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 20 Mar, 1959 to 30 Mar, 1959, that I last saw the deceased alive on 30 March, 1959, and that death occurred at 10:08 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 121 Cathedral St., Annapolis — DATE SIGNED: 30 Mar 59

PHYSICIAN'S NAME (Type)

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/2/59
22c. NAME OF CEMETERY OR CREMATORY: Balto. Nat'l Cemetery
22d LOCATION (City, town, or county): Balto. City — (State): Md

23 FUNERAL DIRECTOR'S SIGNATURE: [signature] — ADDRESS: [illegible]

24a REC'D BY REGISTRAR — DATE: APR 6 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

I

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re[illegible]ed by the hospital or attending physician.

TO FUNER[illegible]ECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 a[illegible] should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2633

CERTIFICATE OF DEATH

02680 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY: A A — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: A. G. General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 115 Conduit
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nora Middle: F. Lost: Simmons
4. DATE OF DEATH: Month: 3 Day: 9 Year: 1959

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept 3-1907
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Benedict Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A

13. FATHER'S NAME: Geo A. Springfield
14. MOTHER'S MAIDEN NAME: Anna Hurley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: George A. Simmons (2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): U REMIA — INTERVAL BETWEEN ONSET AND DEATH: 72 HOURS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) HYDRONEPHROSIS — unknown
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): HEPATITIS, INFECTIOUS
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/26, 1958 to 3/9, 1959, that I last saw the deceased alive on 3/9, 1959, and that death occurred at 7:30 P.M. from the causes and on the date stated above.
ACTUAL SIGNATURE: Edward L Beck M.D. ADDRESS (Street, city or town, state): 41 Southgate Ave DATE SIGNED: 3/11/59
PHYSICIAN'S NAME (Type): Edward L. Beck, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-12-59
22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemt
22d. LOCATION (City, town, or county) (State): Annapolis Md

23. FUNERAL DIRECTOR'S SIGNATURE: John M. Sayler Sons ADDRESS: Annapolis Md
24a. REC'D BY REGISTRAR DATE: MAR 12 '59
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2634

Reg. Dist. No. 02681

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Anne Arundel General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marley (Glen Burnie P.O.)
d. STREET ADDRESS: 201 - Marley Neck Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Florence; Middle: Ann; Last: Smith
4. DATE OF DEATH: Month: March; Day: 12; Year: 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 11, 1959
9. AGE (In years last birthday): ___ yrs.
IF UNDER 1 YEAR: Months: ___ Days: ___
IF UNDER 24 HRS: Hours: 17 Min.: 35
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: William Franklin Smith
14. MOTHER'S MAIDEN NAME: Ruth Elaine Ross
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
INFORMANT: Mother
Address: Marley Park, Glen Burnie, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Prematurity
DUE TO (b): (Unknown Cause.)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 17 Hrs 35 Min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: ___ a. m. / p. m. Month: ___ Day: ___ Year: 19___
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/11 19 59 to 3/12 19 59 that I last saw the deceased alive on March 12, 1959, and that death occurred at 9:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Albert L. Anderson M.D.
ADDRESS (Street, city or town, state): 44 Southgate Ave. Annapolis, Md.
DATE SIGNED: 3/14/59
PHYSICIAN'S NAME (Type): Dr. Albert L. Anderson 44 Southgate Ave., Annapolis, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 16 '59
22c. NAME OF CEMETERY OR CREMATORY: Glen Haven
22d. LOCATION (City, town, or county) (State): Glen Burnie, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: F. J. Seipp
ADDRESS: Glen Burnie, Md.
24a. REC'D BY REGISTRAR DATE: MAR 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

2063121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2693

CERTIFICATE OF DEATH

Reg. Dist. No. 02682

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millersville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Route 1 Box 436

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: A. A.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Millersville
d. STREET ADDRESS: Route 1 Box 436
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Viola — Middle: — Last: Steprey

4. DATE OF DEATH: Month: 3 — Day: 31 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: Col.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-19-1894

9. AGE (In years last birthday): 64 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Millersville, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Hall

14. MOTHER'S MAIDEN NAME: Martha Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no (or unknown)): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Maude L Johnson — Address: Millersville, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive cardiac failure — INTERVAL BETWEEN ONSET AND DEATH:
4541
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-22-58, 19____ to 3-31-59, 19____, that I last saw the deceased alive on 3-30-59, 19____, and that death occurred at 7:45 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C. T. Allen M.D. — ADDRESS (Street, city or town, state): 64 Cathedral St — DATE SIGNED:

PHYSICIAN'S NAME (Type): A. T. ALLEN — Annapolis, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 4-4-59

22c. NAME OF CEMETERY OR CREMATORY: John Wesley

22d. LOCATION (City, town, or county) (State): Waterbury, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese Jr — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR DATE: APR 3 '59

24b. REGISTRAR'S SIGNATURE: Clinton A. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02683

2694

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH
a COUNTY A. A. Co. MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a STATE Md. b COUNTY A. A. Co.

b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ordnance Rd. Curtis Bay

c LENGTH OF STAY IN 1b life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Curtis Bay

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

d STREET ADDRESS Ordnance Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Stella Middle Hammond Last Stoll

4 DATE OF DEATH Month March Day 20, Year 1959

5. SEX Female

6 COLOR OR RACE white

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH Dec. 2, 1879

9. AGE (In years last birthday) 79 yrs.

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10b KIND OF BUSINESS OR INDUSTRY

11 BIRTHPLACE (State or foreign country) A. A. Co. Md.

12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John T. Hammond

14. MOTHER'S MAIDEN NAME Camsadel Shipley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17 INFORMANT Address Mrs. Dorothy S. Oxley 1004 Stewart Lane GlenBurnie Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Myocardial Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Influenza

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 3-14-, 1959 to 3-20-, 1959 that I last saw the deceased alive on 3-14-, 1959, and that death occurred at 12:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Louis J Glass M.D. ADDRESS (Street, city or town, state) 320 Patapsco Ave DATE SIGNED 3/20/59

PHYSICIAN'S NAME (Type) Louis J. Glass M.D. 320 Patapsco Ave.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF March 23, 1959

22c NAME OF CEMETERY OR CREMATORY Cedar Hill

22d LOCATION (City, town, or county) (State) A. A. Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John O. Mitchell & Sons Inc. 1900 Eutaw Place

24a REC'D BY REGISTRAR DATE MAR 23 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2695 — Reg. Dist. No. 02684

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: ANNE ARUNDEL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CROWNSVILLE
c. LENGTH OF STAY IN 1b: 7 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: CROWNSVILLE

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) — a. STATE: MARYLAND — b. COUNTY: DORCHESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HURLOCK
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: IRVING — Middle: — — Last: THOMAS

4. DATE OF DEATH: Month: 3 — Day: 14 — Year: 1959

5. SEX: Male — 6. COLOR OR RACE: N — 7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ] — 8. DATE OF BIRTH: Dec. 14; 1909 — 9. AGE (In years last birthday): 49 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer — 10b. KIND OF BUSINESS OR INDUSTRY: rural — 11. BIRTHPLACE (State or foreign country): Md USA — 12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Charles Thomas (dec) — 14. MOTHER'S MAIDEN NAME: Anne Thomas (dec)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO: — — 17. INFORMANT — Address: HOSPITAL RECORDS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonitis
223X
DUE TO (b): Hemiplegia post Surgical.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Sub-dural Hygroma.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 2x Syphilis + Decubitus Ulcers. — 19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work [ ] Not while at work [ ] — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to 3/13, 19 59, that I last saw the deceased alive on 3/14, 1959, and that death occurred at 9:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D. — ADDRESS (Street, city or town, State): Crownsville State Hospital — DATE SIGNED

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M.D. — Crownsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: March 19, 1959 — 22c. NAME OF CEMETERY OR CREMATORY: Thomestown Cemetery — 22d. LOCATION (City, town, or county) (State): near East New Market, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. J. Tumpleton & Son, Funeral Home, Md. — 24a. REC'D BY REGISTRAR DATE: MAR 17 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2696

CERTIFICATE OF DEATH

Reg. Dist. No. 02685

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1mo 7days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Millersville
d. STREET ADDRESS: Route 1 - Box 26
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James; Middle: ; Last: Ward

4. DATE OF DEATH: Month: 3/12; Day: ; Year: 1959

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 25, 1884

9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months: ; Days:
IF UNDER 24 HRS: Hours: ; Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Ward

14. MOTHER'S MAIDEN NAME: Missouri

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 220-09-3102

17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b): Aortic Insufficiency

DUE TO

(c): Syphilitic Cardiovascular Disease

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): ----------

20c. TIME OF INJURY: Month, Day, Year, Hour o. m. p. m.: -000- 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ------

20f. (City or town) (County) (State): ---------

21. I certify that I attended the deceased from 2/5, 1959 to 3/12, 1959, that I last saw the deceased alive on 3/12, 1959, and that death occurred at 6:35P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): Crownsville State Hospital, Md.
DATE SIGNED: 3/13/59

PHYSICIAN'S NAME (Type): L. BENEDICT M.D.
Crownsville State Hospital, Md. 3/13/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/15/59
22c. NAME OF CEMETERY OR CREMATORY: John Wesley
22d. LOCATION (City, town, or county) (State): Waterbury, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese
ADDRESS: Union Bridge, Md.

24a. REC'D BY REGISTRAR DATE: MAR 16 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2697 — Reg. Dist. No. — 02686

1 PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 8mo 11 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 619 N. Fremont Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Nathaniel — Last: Waters
4. DATE OF DEATH: Month: 3 — Day: 4 — Year: 19 59
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/6/92
9. AGE (In years last birthday): 66 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Receiving Freight
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13. FATHER'S NAME: John Waters
14. MOTHER'S MAIDEN NAME: Georgianna
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 218-10-9883
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — 540.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Post Surgical - Peptic Ulcer
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary Tuberculosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year — Hour — p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/23, 19 58 to 3/4, 19 59, that I last saw the deceased alive on 3/4, 19 59, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lionel McHenry Mapp, M.D. — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 3/5/59
PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D. — Crownsville State Hospital, Md. — 3/5/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 3/7/59
22c. NAME OF CEMETERY OR CREMATORY: Ivy Chapel
22d. LOCATION (City, town, or county): Va Clarence (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Charles A. Hill — ADDRESS: 6616 Barre St
24a. REC'D BY REGISTRAR DATE: MAR 12 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2635 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11257

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: — Last: WELLS

4. DATE OF DEATH: Month: March — Day: 16, — Year: 1959

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/5/05

9. AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): A. A. Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Stepney Brown

14. MOTHER'S MAIDEN NAME: Annie Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unk'wn) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Robert Wells — Address: Anna. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Syncope during anesthesia with pentothal and nitrous oxide.
(b):
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Russell S Fisher M.D.

EXAMINER'S NAME (Type): Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 3/17/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-19-59

22c. NAME OF CEMETERY OR CREMATORY: Brewer Hill

22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: William Reese, Sr. — ADDRESS: Anna, Md.

24a. REC'D BY REGISTRAR DATE: MAR 18 '59

24b. REGISTRAR'S SIGNATURE: Arthur A. Stuart

VS. A15ME
5M 2 '57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2698 CERTIFICATE OF DEATH

Reg. Dist. No. 02658

1. PLACE OF DEATH
a. COUNTY: Anne Ar. County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Orchard Beach Md.
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: A.A.Ct. Md.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Orchard Beach Pasadena Md.
d. STREET ADDRESS: 7912 Seabreeze Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Rosalie Middle: [illegible] Last: Hurt

4. DATE OF DEATH: Month: March Day: 26 Year: 1959

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr. 2, 1884

9. AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Balto. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wm. Hubbard

14. MOTHER'S MAIDEN NAME: Rose Fitzpatrick

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Alice Hurt Address: 7912 Seabreeze Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 2days
DUE TO (b): General Arteriosclerosis — 6 mos
DUE TO (c): Arterial Hypertension — 6 mo.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 2, 1928, to March 26, 1959, that I last saw the deceased alive on March 26, 1959, and that death occurred at 1.3x P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C B Wheeltle M.D. ADDRESS (Street, city or town, state): 1279 William St DATE SIGNED: 3/30/59

PHYSICIAN'S NAME (Type): C B WHEELTLE Balto 30 Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/30/59

22c. NAME OF CEMETERY OR CREMATORY: Balti. Cre

22d. LOCATION (City, town, or county) (State): 2nd of North Ave. Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: KNIGHT FUNERAL HOME 1216 S. Charles St.

24a. REC'D BY REGISTRAR DATE: MAR 30 '59

24b. REGISTRAR'S SIGNATURE: Arthur B. Hurst

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2699 — Reg. Dist. No. 02689

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Crownsville
c. LENGTH OF STAY IN 1b: 1mo 5days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Crownsville State Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 407 N. Payson Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Louvenia — Middle — Last Williams

4. DATE OF DEATH: Month 3 — Day 10 — Year 19 59

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1895

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Washington N.C.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Richard Herring

14. MOTHER'S MAIDEN NAME: Rosie ?

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Aortic Insufficiency

DUE TO

(c) Syphilis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Uremia and Anemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ----------

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. ----- 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ----------

20f. (City or town) (County) (State) ----------

21. I certify that I attended the deceased from 2/5, 19 59, to 3/10, 19 59, that I last saw the deceased alive on 3/10, 19 59, and that death occurred at 5:00A. M, from the causes and on the date stated above

ACTUAL SIGNATURE: Lionel McHenry Mapp M.D — ADDRESS (Street, city or town, state): Crownsville State Hospital, Md. — DATE SIGNED: 3/10/59

PHYSICIAN'S NAME (Type): Lionel McHenry Mapp, M. D. — Crownsville State Hospital, Md. — 3/10/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 14, 59

22c. NAME OF CEMETERY OR CREMATORY: Mt. Auburn Cem.

22d. LOCATION (City, town, or county) (State): Balto. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Mrs Kate R. Wilkins — ADDRESS: 322 N Schroeder St

24a. REC'D BY REGISTRAR DATE: MAR 16 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2700 CERTIFICATE OF DEATH

02690

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pasadena Md
c. LENGTH OF STAY IN 1b: 9 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Lake Waterford

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: A A
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lake Waterford
d. STREET ADDRESS: Pasadena Md
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) — First: Raymond — Middle: Napoleon — Last: Windsor

4. DATE OF DEATH — Month: March — Day: 9 — Year: 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 29 1890

9. AGE (In years last birthday): 68 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coxwain

10b. KIND OF BUSINESS OR INDUSTRY: Navy

11. BIRTHPLACE (State or foreign country): Churchtown Md

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John Windsor

14. MOTHER'S MAIDEN NAME: Howe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Navy 1st world war

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT — Address: wife Henrietta Windsor

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive C. V. disease
DUE TO (c): Gen. arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year 19 — Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1955, 19__ to 1959, 19__ that I last saw the deceased alive on 3-7-59, 19__, and that death occurred at 11 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert R. Holm M.D. — ADDRESS (Street, city or town, state): Severna Park Md — DATE SIGNED: 3-9-59

PHYSICIAN'S NAME (Type): Robert R. Holm

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 12, 1959

22c. NAME OF CEMETERY OR CREMATORY: Loudon Park

22d. LOCATION (City, town, or county) (State): Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: A. V. Singleton — ADDRESS: Glen Burnie, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 12 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11,4 FilmG239 3-12-59 et

2636 **CERTIFICATE OF DEATH** Reg. Dist. No. 02691

1. PLACE OF DEATH
a. COUNTY: Anne Arundel — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Anne Arundel General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Odenton
d. STREET ADDRESS: 1st St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Charlie — Middle: E. — Last: YOUNG

4. DATE OF DEATH: Month: March — Day: 2, — Year: 1959

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 23 Dec 58

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: 2 — Days: 10 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward Young

14. MOTHER'S MAIDEN NAME: ERVALEE V. COLE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mother — Address: SAME AS #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

7542

DUE TO (b): Congenital intraventricular septal defect + pulmonary hypertension since birth

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bilateral bronchopneumonia - Congenital 'horseshoe' renal defect

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 23 Feb, 1959 to 2 MAR, 1959, that I last saw the deceased alive on 2 MAR, 1959, and that death occurred at 9:15 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James I. Hudson, Jr. M.D. — ADDRESS (Street, city or town, state): RIVER CLUB ESTATES — DATE SIGNED: 3 MAR 59

PHYSICIAN'S NAME (Type): JAMES I. HUDSON JR. — EDGEWATER, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: March 5, 1959

22c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Comet

22d. LOCATION (City, town, or county) (State): Annapolis, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Hopping Funeral Home — ADDRESS: Annapolis, Md.

24a. REC'D BY REGISTRAR — DATE: MAR 9 '59

24b. REGISTRAR'S SIGNATURE: Anthony S. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

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FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2701 Reg. Dist. No. 02692

1. PLACE OF DEATH
a. COUNTY: Anne Arundel MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Severn
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Old Quaterfield Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Same b. COUNTY: Same
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Same
d. STREET ADDRESS: Same
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last: Denise Dianne Young
4. DATE OF DEATH Month Day Year: March 26th. 1959

5. SEX: F.
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/25/59
9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR: Months 2 Days 1 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Bowling Green, Kentucky.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Young
14. MOTHER'S MAIDEN NAME: Ruth Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Sergeant and Mrs. Wm. Young (parents)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Suffocation — INTERVAL BETWEEN ONSET AND DEATH: Sudden
9240
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Baby's face was in direct contact with the pillow.
20c. TIME OF INJURY Month, Day, Year Hour a. m.: Unknown 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Crib (Home)
20f. (City or town) (County) (State): Severn, Md. A.A.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gustave H. Faubert M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED: 3/26/59
EXAMINER'S NAME (Type): Gustave H. Faubert, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 29, 1959
22c. NAME OF CEMETERY OR CREMATORY: Fair View Cemetery
22d. LOCATION (City, town, or county) (State): Bowling Green, Kentucky.

23. FUNERAL DIRECTOR'S SIGNATURE: Richard V. Leighton ADDRESS: Glen Burnie, Maryland
24a. REC'D BY REGISTRAR DATE: MAR 30 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMD. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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